QUARTERLY REPORT ON ORGANIZATIONAL PERFORMANCE EXCELLENCE

FOURTH STATE FISCAL QUARTER 2017

April, May, June 2017

Sharon L. Sprague
Superintendent
August 11, 2017

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Introduction

This edition of the Dorothea Dix Psychiatric Center Quarterly Report on Organizational Performance Excellence is designed to address overall organizational performance in a systems improvement approach instead of a purely compliance approach.

There are three major sections that make up this report:

The first section reflects traditional measures related to Comparative Statistics.

The second section describes the hospital's performance with regard to Joint Commission performance measures that are derived from the Hospital Based Inpatient Psychiatric Services (HBIPS) and priority focus areas that are referenced in the Joint Commission standards:

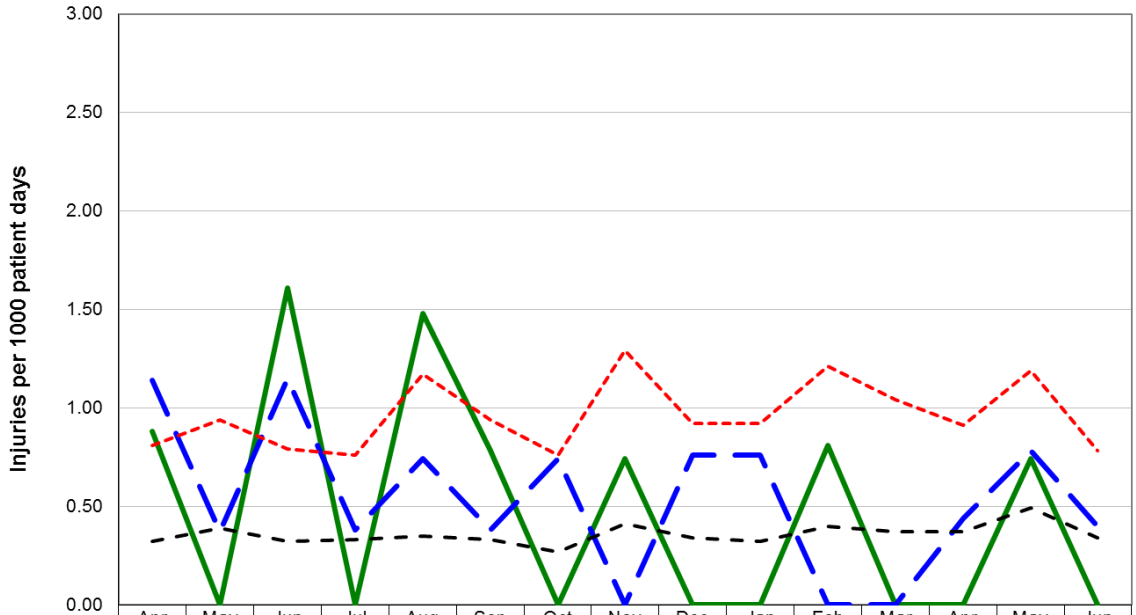
I. Data Collection (PI.01.01.01)
II. Data Analysis (PI.02.01.01, PI.02.01.03)
III. Performance Improvement (PI.03.01.01)

The third section encompasses those departmental process improvement projects that are designed to improve the overall effectiveness and efficiency of the hospital's operations and contribute to the system's overall strategic performance excellence.

As with any change in how organizations operate, there are early adopters and those whose adoption of system changes is delayed. It is anticipated that over the next year, further contributors to this section of strategic performance excellence will be added as opportunities for improvement and methods of improving operational functions are defined.

COMPARATIVE STATISTICS

Patient Injury Rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	0.88	0.00	1.61	0.00	1.48	0.78	0.00	0.74	0.00	0.00	0.81	0.00	0.00	0.74	0.00
Riverview	1.14	0.37	1.15	0.38	0.74	0.38	0.74	0.00	0.76	0.76	0.00	0.00	0.44	0.78	0.40
Ntl Mean	0.32	0.39	0.32	0.33	0.35	0.33	0.27	0.41	0.34	0.32	0.40	0.37	0.37	0.49	0.34
+1 StDev	0.81	0.94	0.79	0.76	1.17	0.94	0.76	1.29	0.92	0.92	1.21	1.04	0.91	1.19	0.78

Number of patient injury incidents that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that one injury occurred for each 2000 inpatient days. The NRI standards for measuring patient injuries differentiate between injuries that are considered reportable to the Joint Commission as a performance measure and those injuries that are of a less severe nature. While all injuries are currently reported internally, only certain types of injuries are documented and reported to NRI for inclusion in the performance measure analysis process. This comparative statistic graph only includes those events that are considered “Reportable” by NRI.

COMPARATIVE STATISTICS

"Non-reportable" injuries include those that require: 1) No Treatment, or 2) Minor First Aid

Reportable injuries include those that require: 3) Medical Intervention, 4) Hospitalization or where, 5) Death Occurred.

Injury Severity:

- No Treatment: The injury received by a patient may be examined by a clinician but no treatment is applied to the injury.
- Minor First Aid: The injury received is of minor severity and requires the administration of minor first aid.
- Medical Intervention Needed: The injury received is severe enough to require the treatment of the patient by a licensed practitioner, but does not require hospitalization.
- Hospitalization Required: The injury is so severe that it requires medical intervention and treatment as well as care of the injured patient at a general acute care medical ward within the facility or at a general acute care hospital outside the facility.
- Death Occurred: The injury received was so severe that it resulted in, or complications of the injury lead to, the termination of the life of the injured patient.

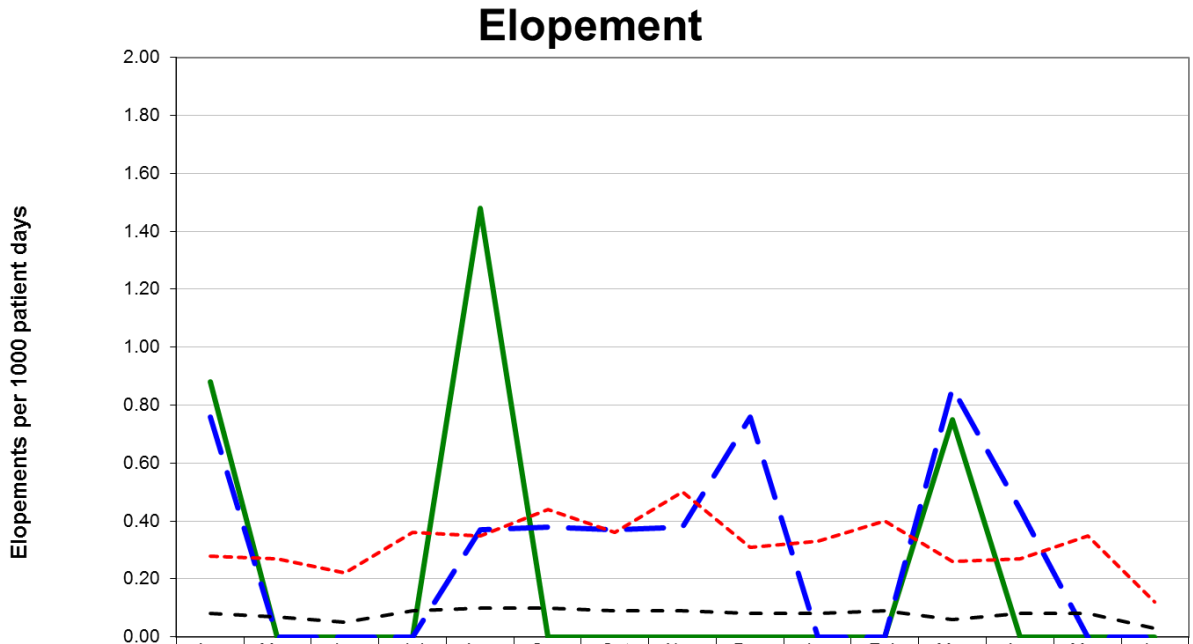
Type and Cause of Injury by Month

Type - Cause	April	May	June	4Q2017
Accident		1		**1**
Fall		1	1	**2**
Other		4	1	**5**
Patient to Patient Incident		1		**1**
Self-Injurious Behavior	3		1	**4**
Total	**3**	**7**	**3**	**13**

Severity of Injury by Month

Severity	April	May	June	4Q2017
No Treatment		4		**4**
Minor First Aid	3	3	3	**9**
Medical Intervention Required				
Hospitalization Required				
Death Occurred				
Total	**3**	**7**	**3**	**13**

COMPARATIVE STATISTICS



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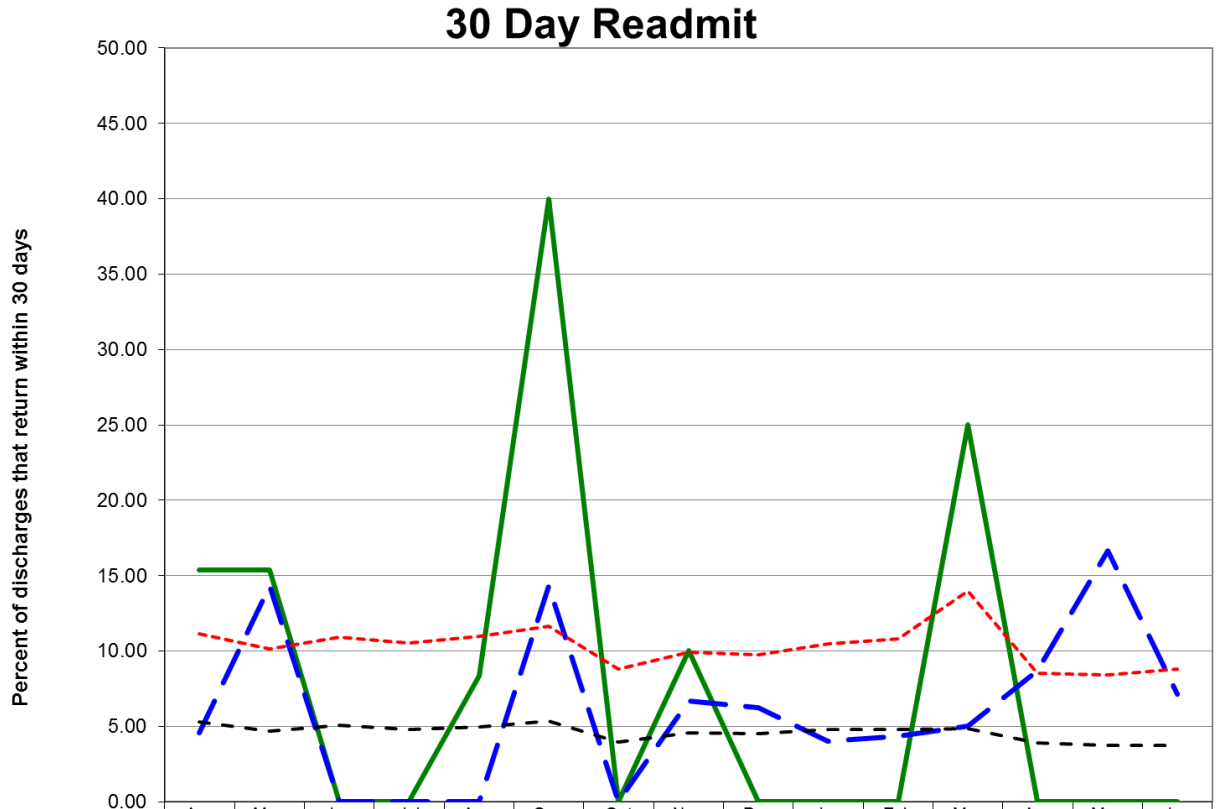
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	0.88	0.00	0.00	0.00	1.48	0.00	0.00	0.00	0.00	0.00	0.00	0.75	0.00	0.00	0.00
Riverview	0.76	0.00	0.00	0.00	0.37	0.38	0.37	0.38	0.76	0.00	0.00	0.86	0.44	0.00	0.00
Ntl Mean	0.08	0.07	0.05	0.09	0.10	0.10	0.09	0.09	0.08	0.08	0.09	0.06	0.08	0.08	0.03
+1 StDev	0.28	0.27	0.22	0.36	0.35	0.44	0.36	0.50	0.31	0.33	0.40	0.26	0.27	0.35	0.12

Number of elopement incidents that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that one elopement occurred for each 4000 inpatient days.

COMPARATIVE STATISTICS

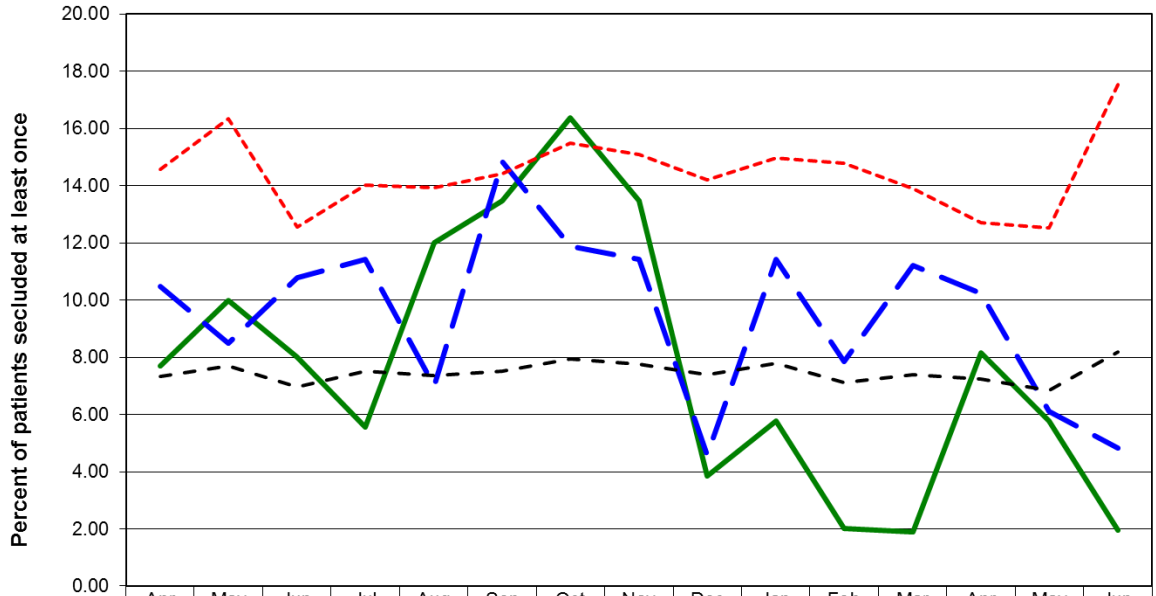


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	15.38	15.38	0.00	0.00	8.33	40.00	0.00	10.00	0.00	0.00	0.00	25.00	0.00	0.00	0.00
Riverview	4.55	14.29	0.00	0.00	0.00	14.29	0.00	6.67	6.25	4.00	4.35	5.00	8.70	16.67	7.14
Ntl Mean	5.30	4.68	5.06	4.78	4.98	5.34	3.96	4.56	4.51	4.78	4.80	4.86	3.93	3.71	3.73
+1 StDev	11.13	10.16	10.92	10.52	10.99	11.65	8.80	9.92	9.74	10.49	10.81	13.98	8.55	8.42	8.82

Percent of discharges from the facility that returned within 30 days of a discharge of the same patient from the same facility. For example, a rate of 10.0 means that 10% of all discharges were readmitted within 30 days.

COMPARATIVE STATISTICS

Percent of Patients Restrained



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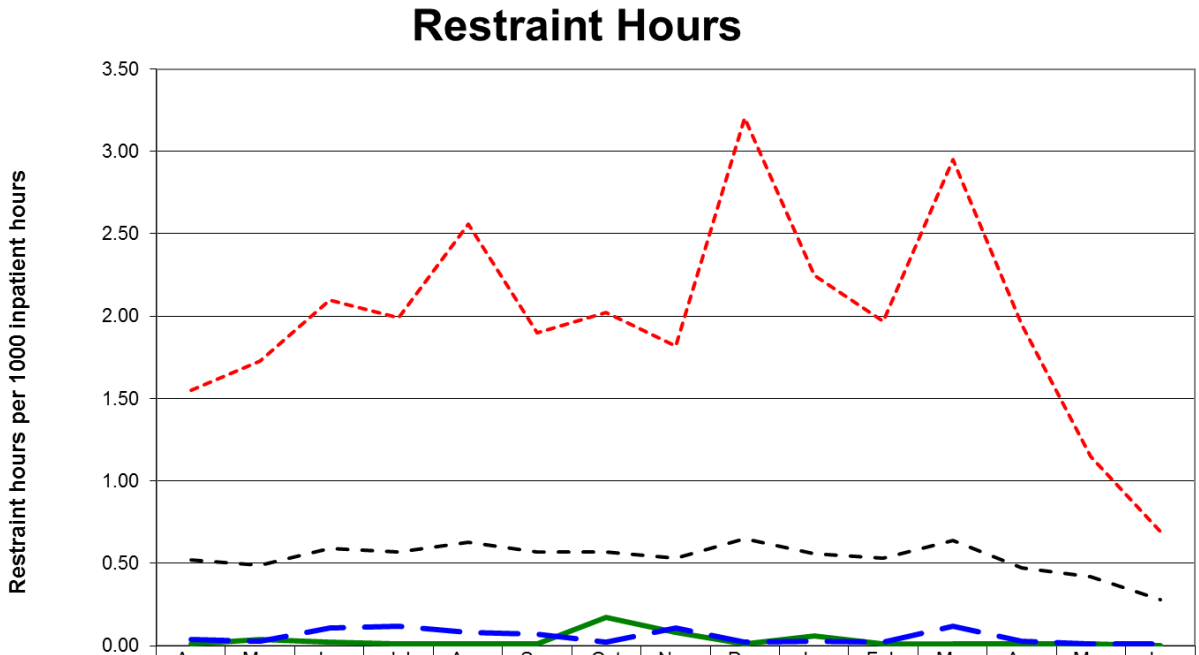
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	7.69	10.00	8.00	5.56	12.00	13.46	16.36	13.46	3.85	5.77	2.00	1.89	8.16	5.77	1.96
Riverview	10.48	8.49	10.78	11.43	7.00	14.85	11.88	11.43	4.59	11.43	7.84	11.22	10.23	6.12	4.81
Ntl Mean	7.33	7.69	6.97	7.50	7.36	7.51	7.93	7.77	7.38	7.79	7.13	7.40	7.24	6.85	8.20
+1 StDev	14.58	16.34	12.56	14.01	13.92	14.42	15.48	15.09	14.21	14.97	14.77	13.90	12.70	12.53	17.52

Percent of unique patients who were restrained at least once. The NRI and Joint Commission standards require that all types of restraint, including manual holds of less than five minutes be included in this indicator. For example, rates of 4.0 means that 4% of the unique patients served were restrained at least once, for any amount of time.

COMPARATIVE STATISTICS



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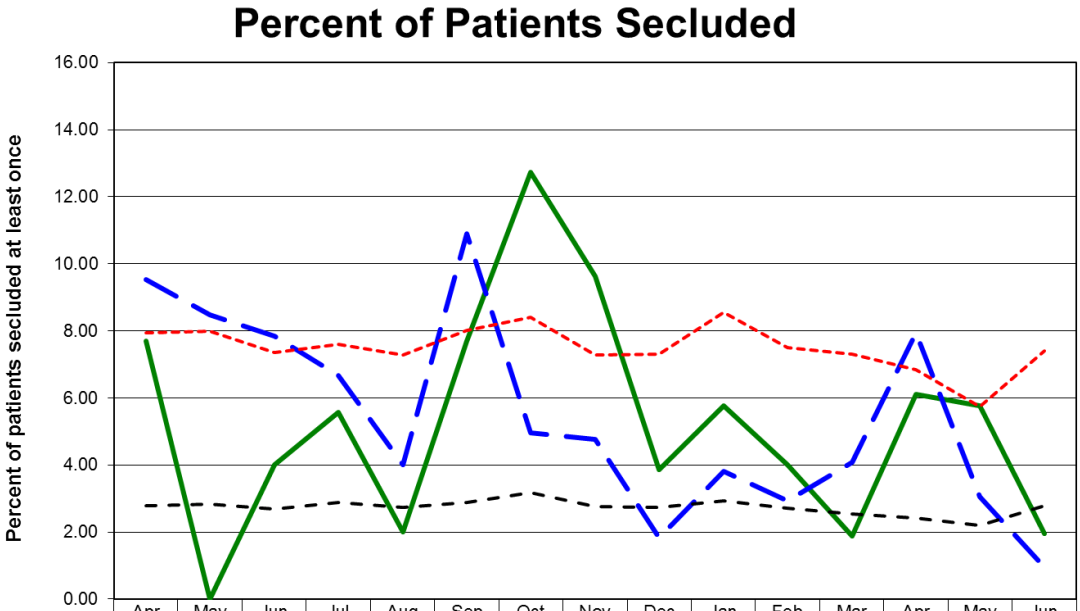
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	0.01	0.04	0.02	0.01	0.01	0.01	0.17	0.08	0.01	0.06	0.01	0.01	0.01	0.01	0.00
Riverview	0.04	0.03	0.11	0.12	0.08	0.07	0.02	0.11	0.02	0.03	0.02	0.12	0.03	0.01	0.01
Ntl Mean	0.52	0.49	0.59	0.57	0.63	0.57	0.57	0.53	0.65	0.56	0.53	0.64	0.47	0.42	0.28
+1 StDev	1.55	1.73	2.10	1.99	2.56	1.90	2.02	1.82	3.20	2.25	1.97	2.95	1.95	1.15	0.69

Number of hour's patients spent in restraint for every 1000 inpatient hours. For example, a rate of 1.6 means that two hours were spent in restraint for each 1250 inpatient hours.

COMPARATIVE STATISTICS



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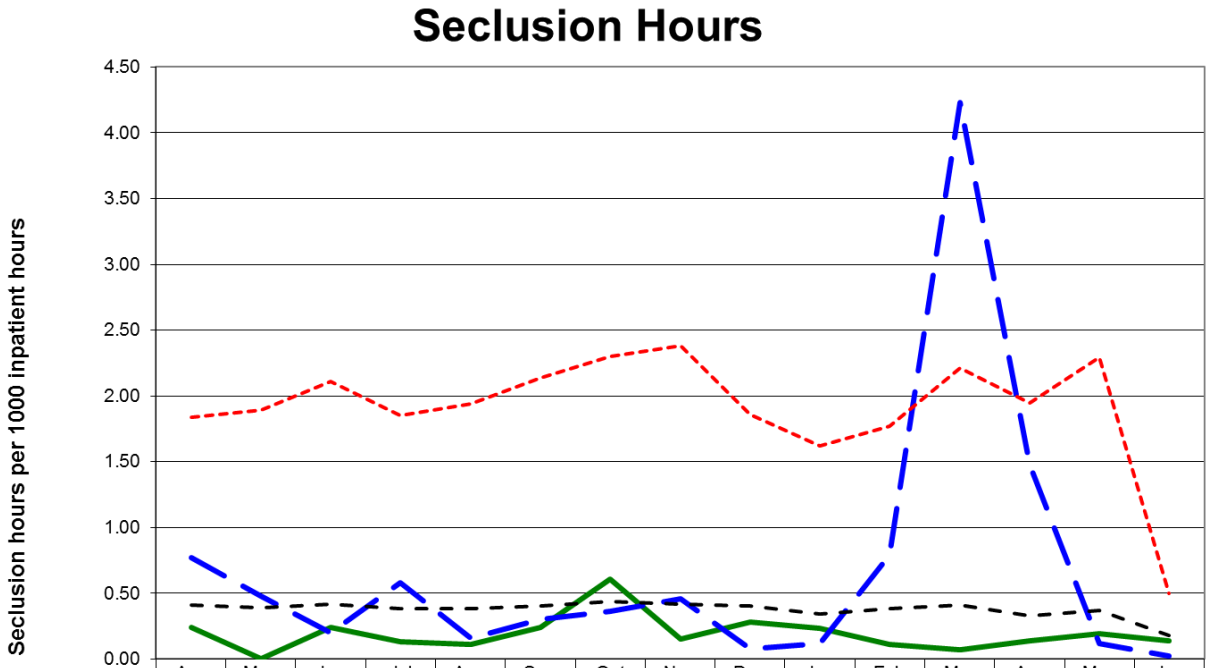
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	7.69	0.00	4.00	5.56	2.00	7.69	12.73	9.62	3.85	5.77	4.00	1.89	6.12	5.77	1.96
Riverview	9.52	8.49	7.84	6.67	4.00	10.89	4.95	4.76	1.83	3.81	2.94	4.08	7.95	3.06	0.96
Ntl Mean	2.79	2.84	2.69	2.88	2.73	2.88	3.17	2.75	2.73	2.94	2.70	2.55	2.42	2.21	2.79
+1 StDev	7.94	7.98	7.36	7.60	7.29	8.02	8.40	7.28	7.31	8.55	7.51	7.31	6.83	5.75	7.40

Percent of unique patients who were secluded at least once. For example, a rate of 3.0 means that 3% of the unique patients served were secluded at least once.

COMPARATIVE STATISTICS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	0.24	0.00	0.24	0.13	0.11	0.24	0.61	0.15	0.28	0.23	0.11	0.07	0.14	0.19	0.14
Riverview	0.77	0.48	0.20	0.58	0.16	0.30	0.36	0.46	0.08	0.12	0.79	4.23	1.48	0.12	0.02
Ntl Mean	0.41	0.39	0.42	0.38	0.38	0.40	0.44	0.42	0.40	0.34	0.38	0.41	0.33	0.37	0.18
+1 StDev	1.84	1.89	2.11	1.85	1.94	2.14	2.30	2.38	1.86	1.62	1.77	2.21	1.95	2.29	0.50

Number of hours patients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that one hour was spent in seclusion for each 1250 inpatient hours.

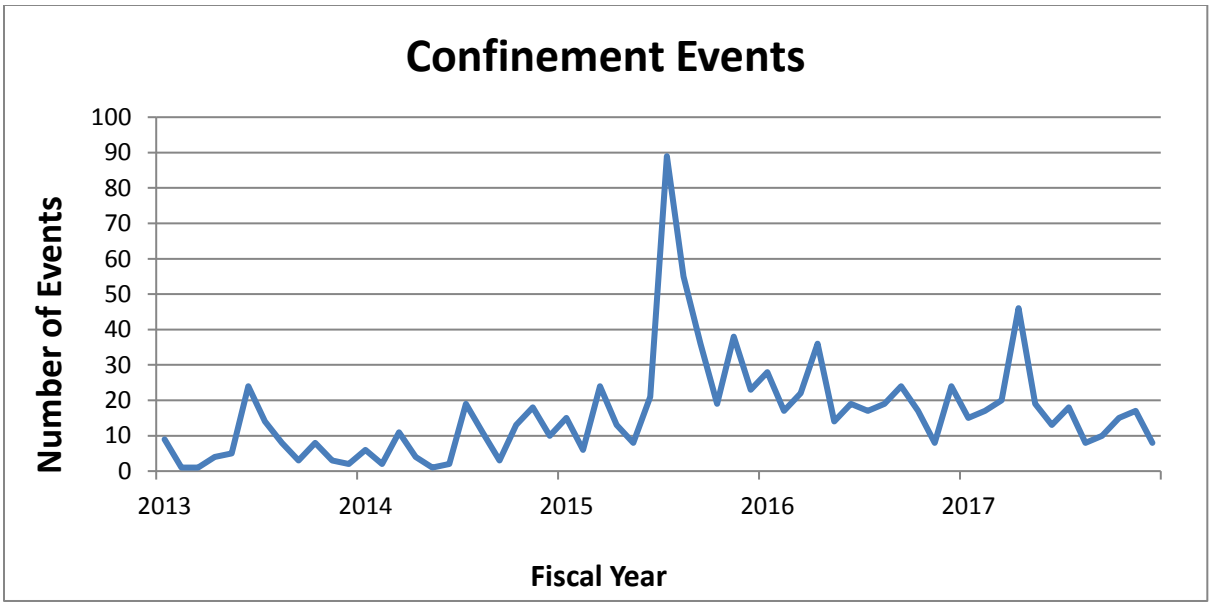
COMPARATIVE STATISTICS

Confinement Event Breakdown

Patient ID	Manual Hold	Mechanical Restraint	Locked Seclusion	Grand Total	% of Total	Cumulative %
MD1305	17		9	**26**	65.00%	65.00%
MD2116	4			**4**	10.00%	75.00%
MD2117	2		2	**4**	10.00%	85.00%
MD2028	1		1	**2**	5.00%	90.00%
MD506	1		1	**2**	5.00%	95.00%
MD2097	1		1	**2**	5.00%	100.00%
	26	**0**	**14**	**40**		

Unit	Manual Hold	Locked Seclusion
Chamberlain	21	13
Hamlin	5	1
Knox	0	0

Event	April	May	June
Manual Hold	10	11	5
Locked Seclusion	5	6	2



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Hospital Based Inpatient Psychiatric Services (HBIPS)

The Inpatient Psychiatric Facility Quality Reporting System (IPFQRS) measures are required by the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (the hospitals accrediting agency). These measures were created due to a request made to The Joint Commission in 2003 to identify and implement a set of core performance measures for hospital-based inpatient psychiatric services. The measures have changed over the years.

IPFQRS Measures	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017
HBIPS-1: Percent of inpatients screened within the first three days of admission for risk of violence to self or others, substance use, psychological trauma history, and patient strengths. *TJC target: 94%*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HBIPS-2: Number of hour's patients spent in physical restraint for every 1000 inpatient hours. *TJC target: < 0.48*	0.01	0.01	0.01	0.17	0.08	0.01	0.06	0.01	0.01	0.01	0.01	0.00
HBIPS-3: Number of hour's patients spent in seclusion for every 1000 inpatient hours. *TJC target: < 0.39*	0.13	0.11	0.24	0.61	0.15	0.28	0.23	0.11	0.07	0.14	0.20	0.14
HBIPS-5: Percept of patients with appropriate justification for discharge on multiple antipsychotic medications. *TJC target: 61%*	60%	67%		100%		0%	100%	100%	100%	100%		100%

*No patients were discharged on multiple antipsychotics this month

Note: TJC targets typically run approximately 6 months behind, the TJC target above was for December 2016.

JOINT COMMISSION

Contract Management

TJC LD.04.03.09 The same level of care should be delivered to patients regardless of whether services are provided directly by the hospital or through contractual agreement. Leaders provide oversight to make sure that care, treatment, and services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively.

4Q2017 Results		
Contractor	**Program Administrator**	**Summary of Performance**
Affiliated Laboratory	Carolyn Dimek Director of Nursing	All indicators met standards
Casella Waste Systems	Mark Faulkner Director of Facilities	All indicators met standards.
CES, Inc.	Mark Faulkner Director of Facilities	All indicators met or exceeded standards.
Comprehensive Pharmacy Services	Carolyn Dimek Director of Nursing	All indicators met or exceeded standards.
Harriman Associates	Mark Faulkner Director of Facilities	No services were provided during this timeframe.
Liberty Healthcare Physicians and/or Mid-Levels On Call	Dr. Michelle Gardner Clinical Director	All indicators met standards.
Liberty Healthcare Psychiatric Nurse Practitioner	Dr. Michelle Gardner Clinical Director	All indicators met standards.
MD-IT Transcription	Michelle Welch Medical Records Administrator	All indicators met standards.
Northeast Cardiology Associates (NECA)	Dr. Michelle Gardner Clinical Director	All indicators met standards.
Norris, Inc.	Mark Faulkner Director of Facilities	All indicators met standards.
Otis Elevator	Mark Faulkner Director of Facilities	All indicators met standards.
Penobscot Community Health Care (PCHC)	Dr. Michelle Gardner Clinical Director	Indicator met standards.
Project Staffing	Carol Davis Business Manager	All indicators exceeded standards.
Securitas	Mark Faulkner Director of Facilities	All indicators met or exceeded standards.

JOINT COMMISSION

UniFirst	Mark Faulkner Director of Facilities	Two indicators did not meet standards: (1) Pickup and delivery turn-around times established were not adhered to and (2) linen received clean & neat in appearance at the hospital due to a lack of quality in the items received this quarter. One indicator met standards.
WBRC Architects Engineers	Mark Faulkner Director of Facilities	All indicators exceeded standards.
Worldwide Travel Staffing	Carolyn Dimek Director of Nursing	All indicators met standards.

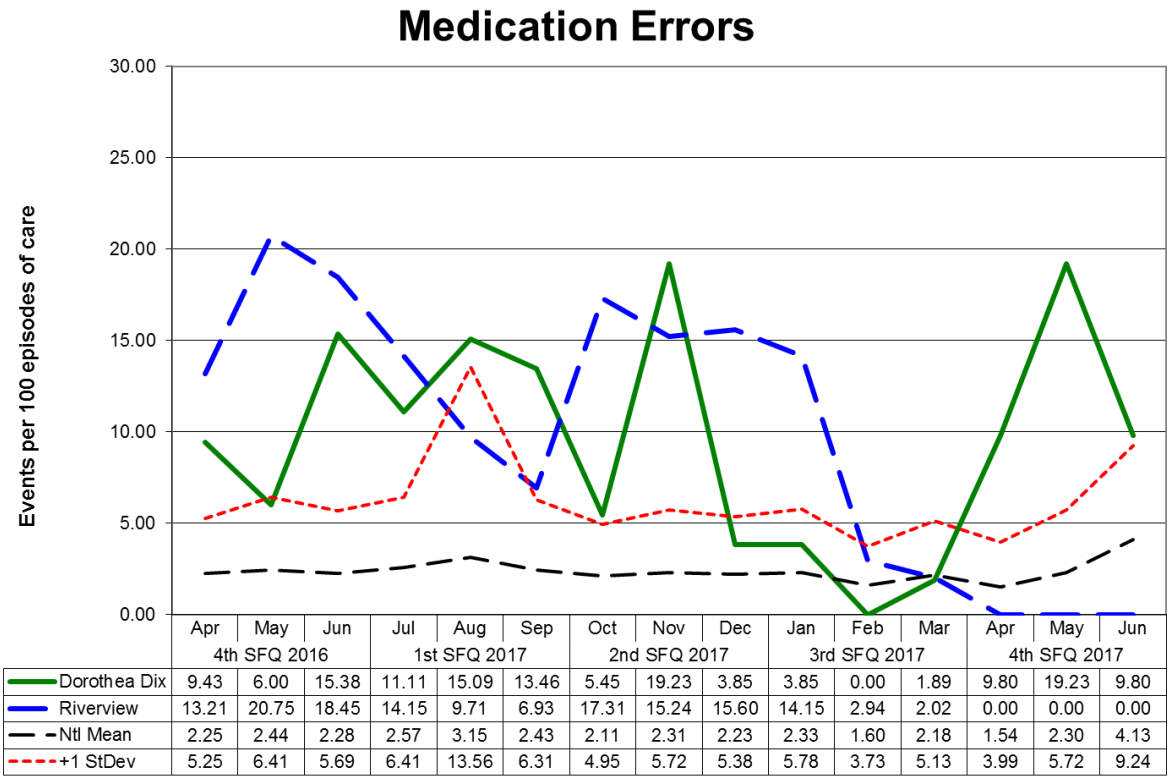
JOINT COMMISSION

Medication Management

Medication Errors and Adverse Reactions

TJC PI.01.01.01 EP14: The hospital collects data on the following: Significant medication errors. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

TJC PI.01.01.01 EP15: The hospital collects data on the following: Significant adverse drug reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)



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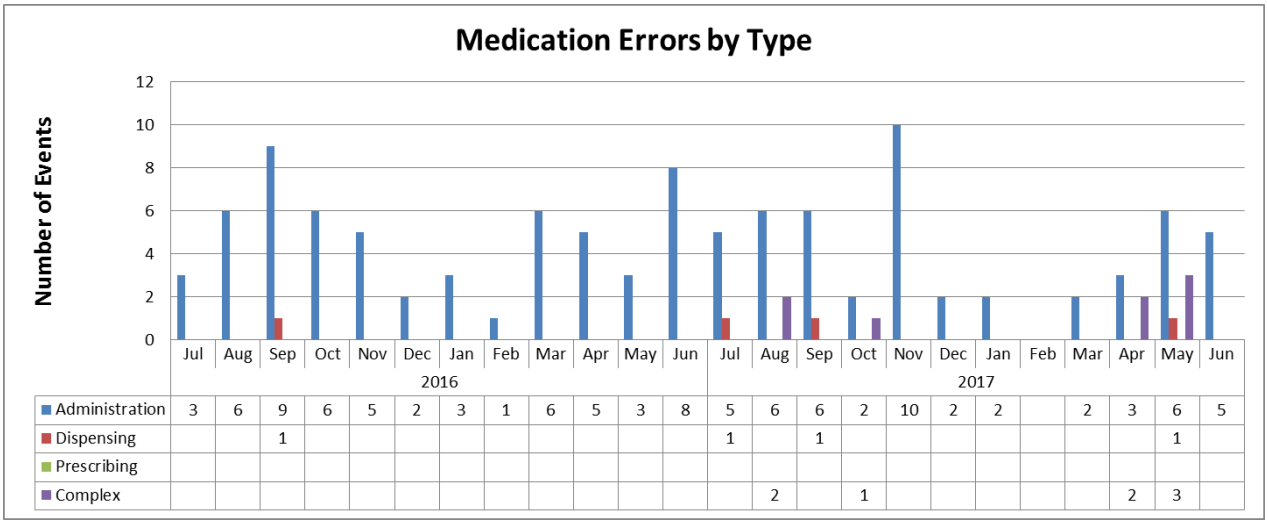
Dorothea Dix	9.43	6.00	15.38	11.11	15.09	13.46	5.45	19.23	3.85	3.85	0.00	1.89	9.80	19.23	9.80
Riverview	13.21	20.75	18.45	14.15	9.71	6.93	17.31	15.24	15.60	14.15	2.94	2.02	0.00	0.00	0.00
Ntl Mean	2.25	2.44	2.28	2.57	3.15	2.43	2.11	2.31	2.23	2.33	1.60	2.18	1.54	2.30	4.13
+1 StDev	5.25	6.41	5.69	6.41	13.56	6.31	4.95	5.72	5.38	5.78	3.73	5.13	3.99	5.72	9.24

Number of medication error events that occurred for every 100 episodes of care (duplicated patient count). For example, a rate of 1.6 means that two medication error events occurred for each 125 episodes of care.

JOINT COMMISSION



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2016												2017											
Administration	3	6	9	6	5	2	3	1	6	5	3	8	5	6	6	2	10	2	2		2	3	6	5
Dispensing			1										1		1								1	
Prescribing																								
Complex														2		1						2	3	

JOINT COMMISSION

Inpatient Consumer Survey

TJC PI.01.01.01 EP16: The hospital collects data on the following: Patient perception of the safety and quality of care, treatment, and services.

In order to gain a perspective on the quality of care provided to our patients from the patient's perspective, Dorothea Dix Psychiatric Center conducts and the Inpatient Customer Survey.

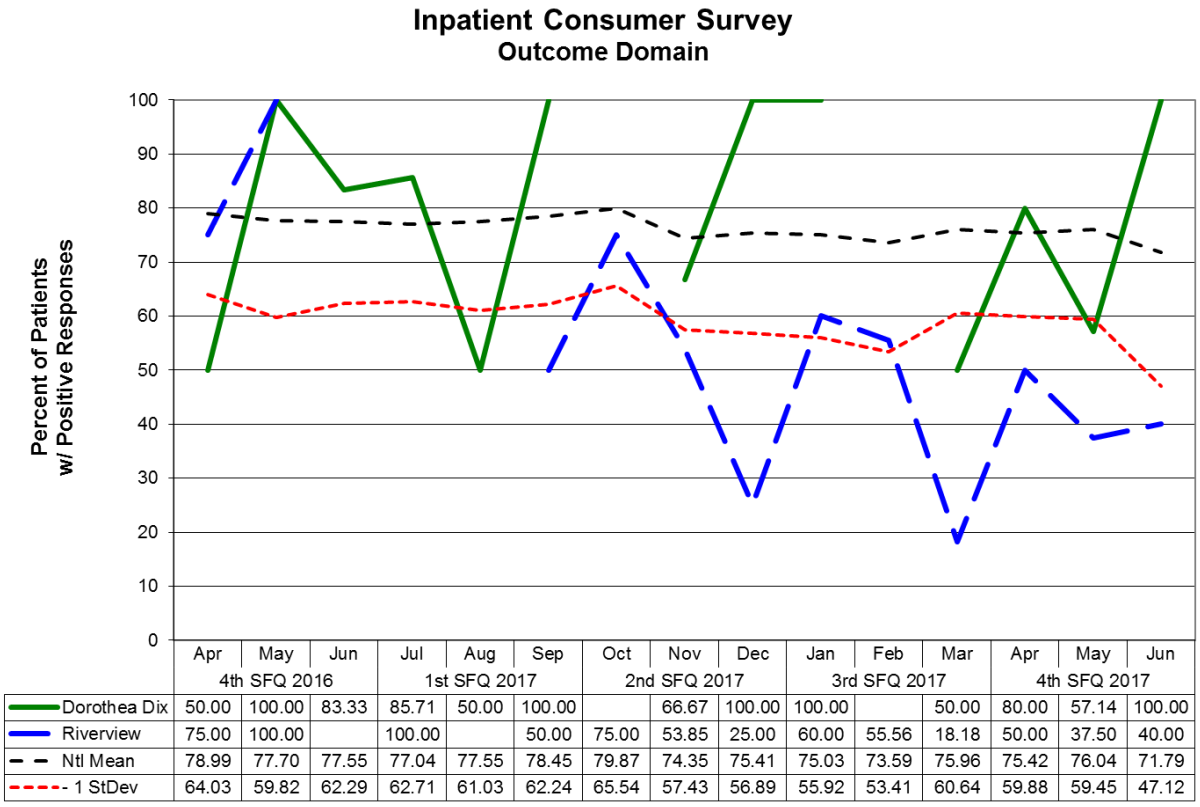
The **Inpatient Customer Survey (ICS)** is a standardized national survey of customer satisfaction. The National Association of State Mental Health Program Directors Research Institute (NRI) collects data from state psychiatric hospitals throughout the country in an effort to compare the results of patient satisfaction in six areas or domains of focus. These domains include Outcomes, Dignity, Rights, Participation, Environment, and Empowerment.

NRI Inpatient Consumer Survey (ICS) Response Rate:

	April	May	June	4Q2017
Number of patients discharged	9	8	7	**24**
Number of survey responses	5	7	1	**13**
Survey response rate	**56%**	**88%**	**14%**	**54%**

Note: The following graphs contain the results of the Inpatient Consumer Survey. If there is no result for a particular month, it indicates that no surveys were completed for that month.

JOINT COMMISSION



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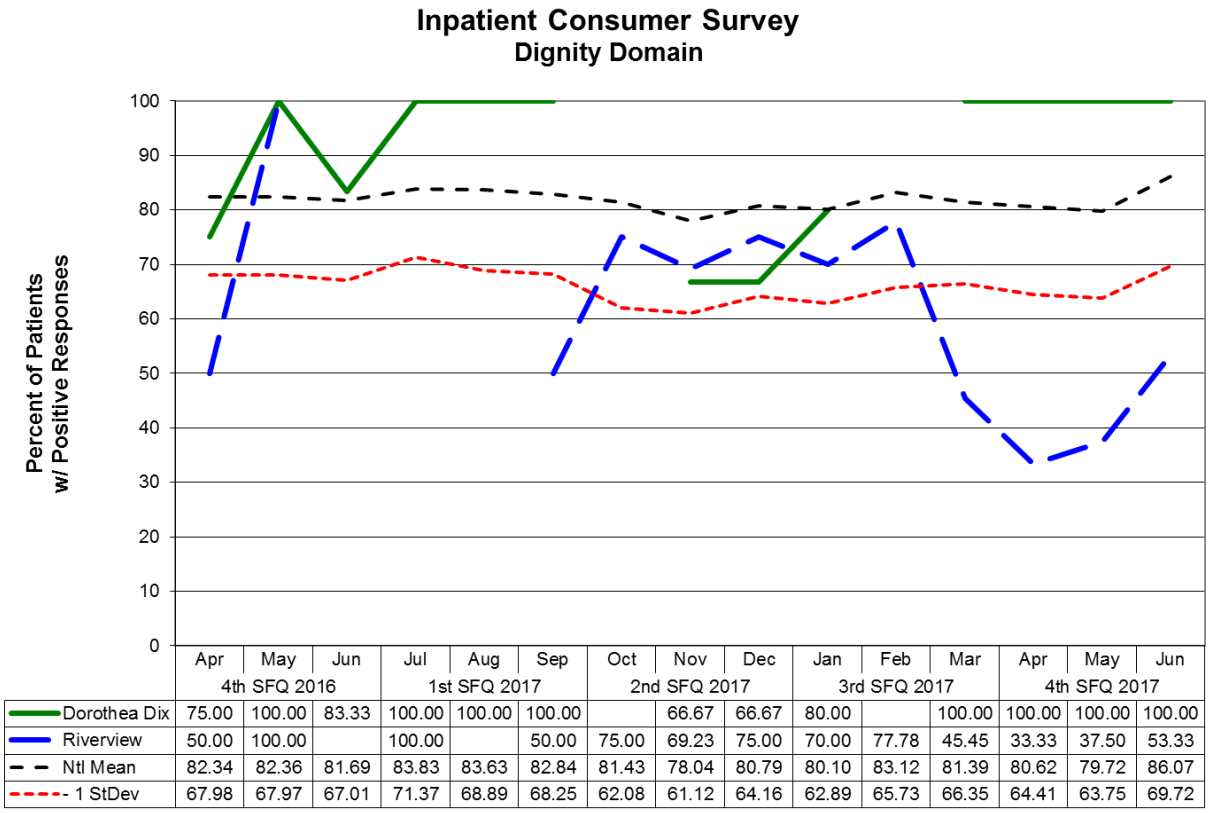
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	50.00	100.00	83.33	85.71	50.00	100.00		66.67	100.00	100.00		50.00	80.00	57.14	100.00
Riverview	75.00	100.00		100.00		50.00	75.00	53.85	25.00	60.00	55.56	18.18	50.00	37.50	40.00
Ntl Mean	78.99	77.70	77.55	77.04	77.55	78.45	79.87	74.35	75.41	75.03	73.59	75.96	75.42	76.04	71.79
- 1 StDev	64.03	59.82	62.29	62.71	61.03	62.24	65.54	57.43	56.89	55.92	53.41	60.64	59.88	59.45	47.12

Outcome Domain

1. I am better able to deal with crisis.
2. My symptoms are not bothering me as much.
3. I do better in social situations.
4. I deal more effectively with daily problems.

JOINT COMMISSION



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Dorothea Dix	75.00	100.00	83.33	100.00	100.00	100.00		66.67	66.67	80.00		100.00	100.00	100.00	100.00
Riverview	50.00	100.00		100.00		50.00	75.00	69.23	75.00	70.00	77.78	45.45	33.33	37.50	53.33
Ntl Mean	82.34	82.36	81.69	83.83	83.63	82.84	81.43	78.04	80.79	80.10	83.12	81.39	80.62	79.72	86.07
- 1 StDev	67.98	67.97	67.01	71.37	68.89	68.25	62.08	61.12	64.16	62.89	65.73	66.35	64.41	63.75	69.72

Dignity Domain

1. I was treated with dignity and respect.
2. Staff here believed that I could grow, change and recover.
3. I felt comfortable asking questions about my treatment and medications.
4. I was encouraged to use self-help/support groups.

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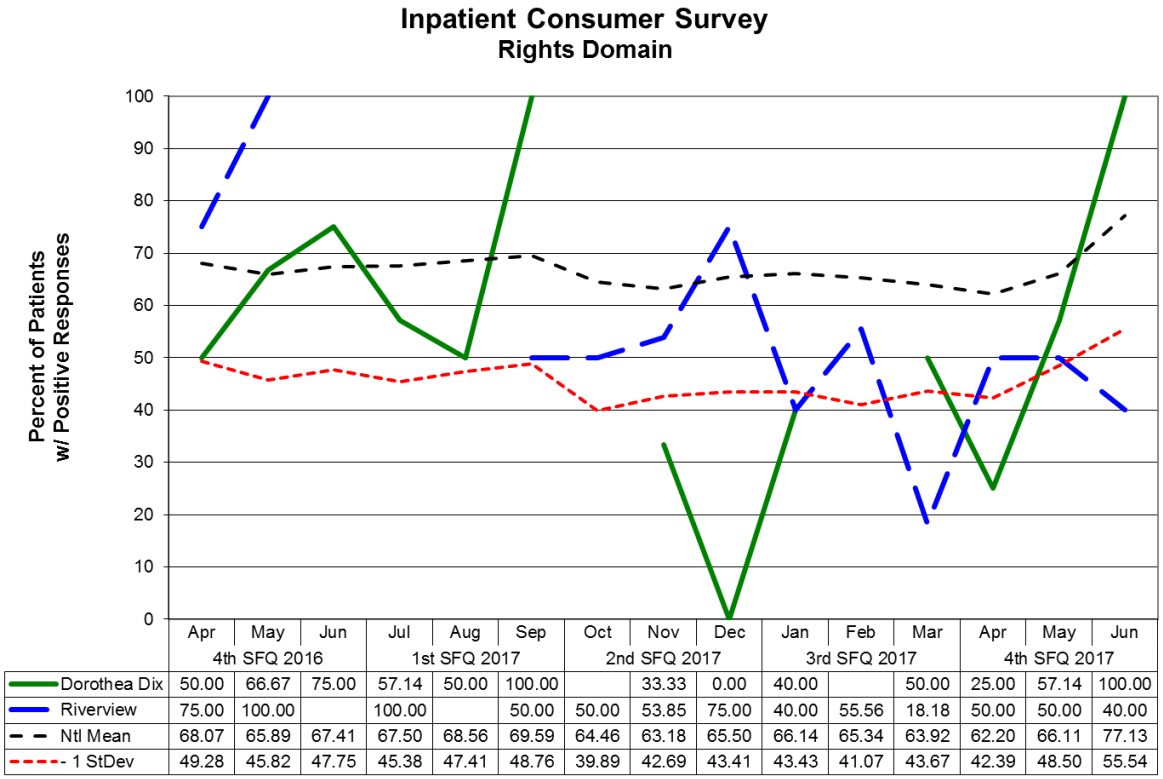

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	50.00	66.67	75.00	57.14	50.00	100.00		33.33	0.00	40.00		50.00	25.00	57.14	100.00
Riverview	75.00	100.00		100.00		50.00	50.00	53.85	75.00	40.00	55.56	18.18	50.00	50.00	40.00
Ntl Mean	68.07	65.89	67.41	67.50	68.56	69.59	64.46	63.18	65.50	66.14	65.34	63.92	62.20	66.11	77.13
- 1 StDev	49.28	45.82	47.75	45.38	47.41	48.76	39.89	42.69	43.41	43.43	41.07	43.67	42.39	48.50	55.54

Rights Domain

1. I felt free to complain without fear of retaliation.
2. I felt safe to refuse medication or treatment during my hospital stay.
3. My complaints and grievances were addressed.

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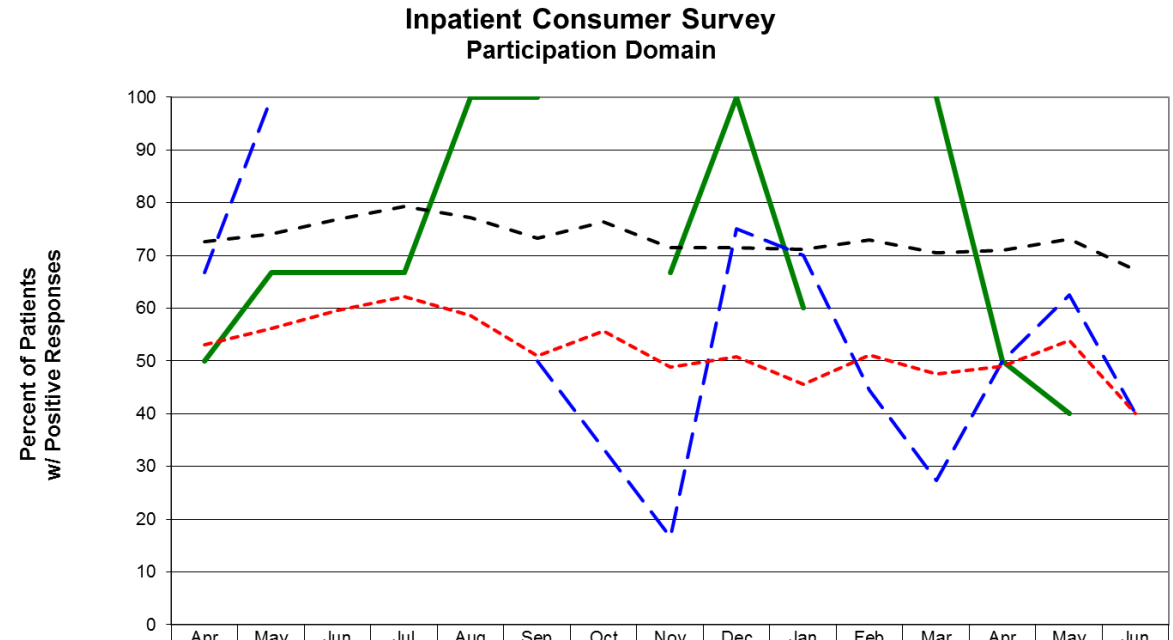

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	50.00	66.67	66.67	66.67	100.00	100.00		66.67	100.00	60.00		100.00	50.00	40.00	
Riverview	66.67	100.00		100.00		50.00	33.33	16.67	75.00	70.00	44.44	27.27	50.00	62.50	40.00
Ntl Mean	72.54	74.14	76.85	79.25	77.20	73.26	76.37	71.41	71.45	71.08	72.97	70.45	70.96	73.07	67.16
- 1 StDev	53.12	56.18	59.56	62.25	58.55	50.91	55.68	48.91	50.77	45.64	51.14	47.60	48.97	53.90	40.03

Participation Domain

1. I participated in planning my discharge.
2. Both I and my doctor, or therapist from the community, were actively involved in my hospital treatment plan.
3. I had an opportunity to talk with my doctor or therapist from the community prior to discharge.

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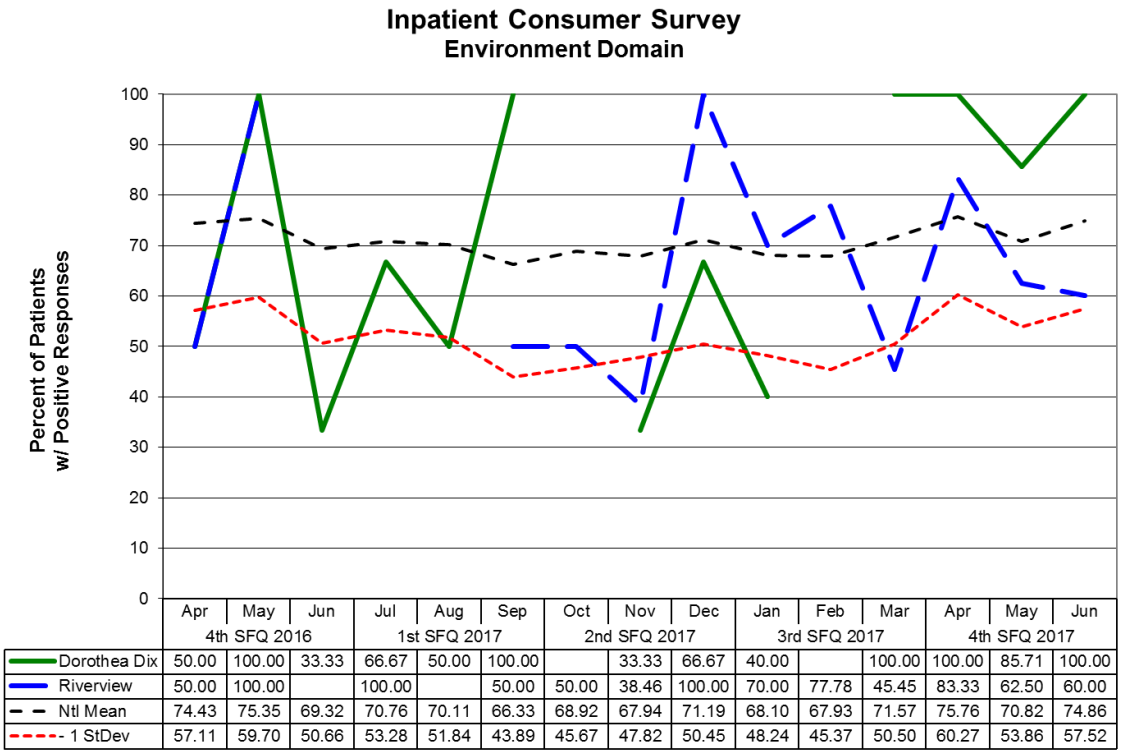

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	50.00	100.00	33.33	66.67	50.00	100.00		33.33	66.67	40.00		100.00	100.00	85.71	100.00
Riverview	50.00	100.00		100.00		50.00	50.00	38.46	100.00	70.00	77.78	45.45	83.33	62.50	60.00
Ntl Mean	74.43	75.35	69.32	70.76	70.11	66.33	68.92	67.94	71.19	68.10	67.93	71.57	75.76	70.82	74.86
- 1 StDev	57.11	59.70	50.66	53.28	51.84	43.89	45.67	47.82	50.45	48.24	45.37	50.50	60.27	53.86	57.52

Environment Domain

1. The surroundings and atmosphere at the hospital helped me get better.
2. I felt I had enough privacy in the hospital.
3. I felt safe while I was in the hospital.
4. The hospital environment was clean and comfortable.

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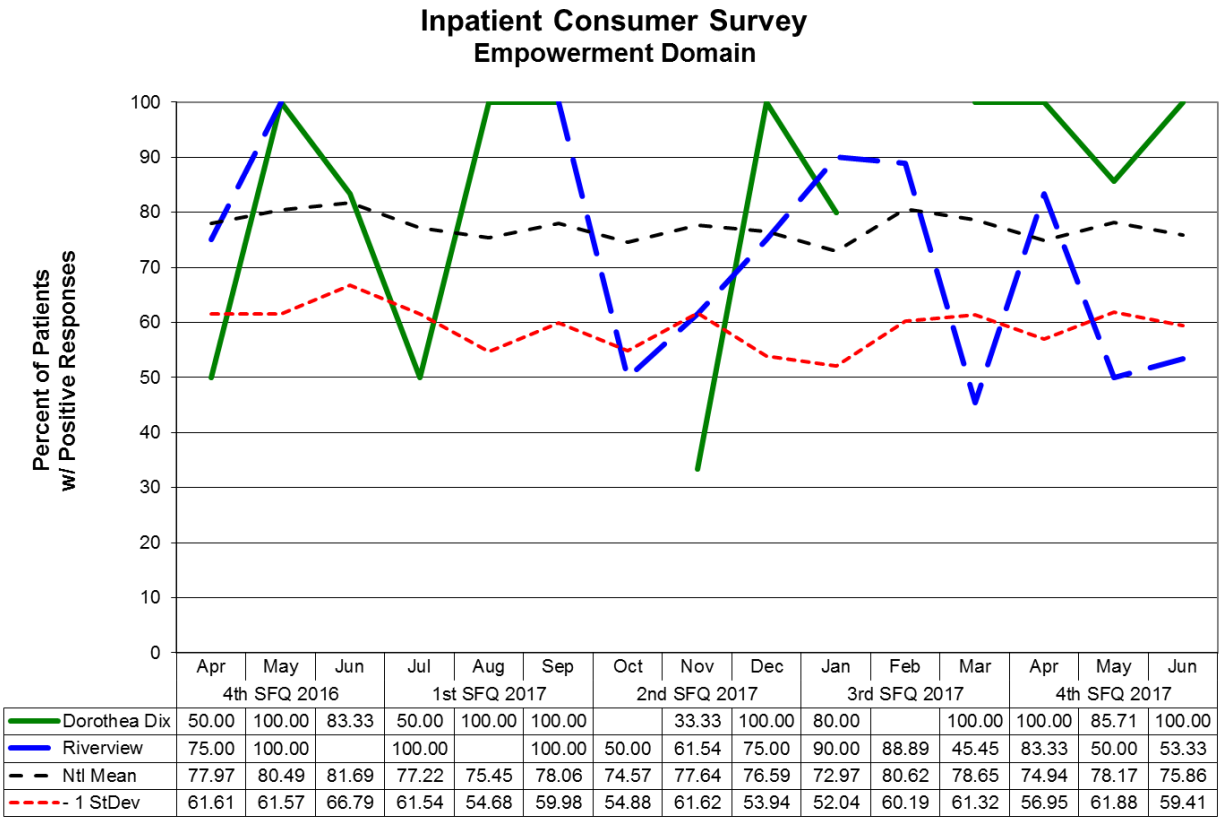

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	4th SFQ 2016			1st SFQ 2017			2nd SFQ 2017			3rd SFQ 2017			4th SFQ 2017		
Dorothea Dix	50.00	100.00	83.33	50.00	100.00	100.00		33.33	100.00	80.00		100.00	100.00	85.71	100.00
Riverview	75.00	100.00		100.00		100.00	50.00	61.54	75.00	90.00	88.89	45.45	83.33	50.00	53.33
Ntl Mean	77.97	80.49	81.69	77.22	75.45	78.06	74.57	77.64	76.59	72.97	80.62	78.65	74.94	78.17	75.86
- 1 StDev	61.61	61.57	66.79	61.54	54.68	59.98	54.88	61.62	53.94	52.04	60.19	61.32	56.95	61.88	59.41

Empowerment Domain

1. I had a choice of treatment options.
2. My contact with my doctor was helpful.
3. My contact with nurses and therapists was helpful.

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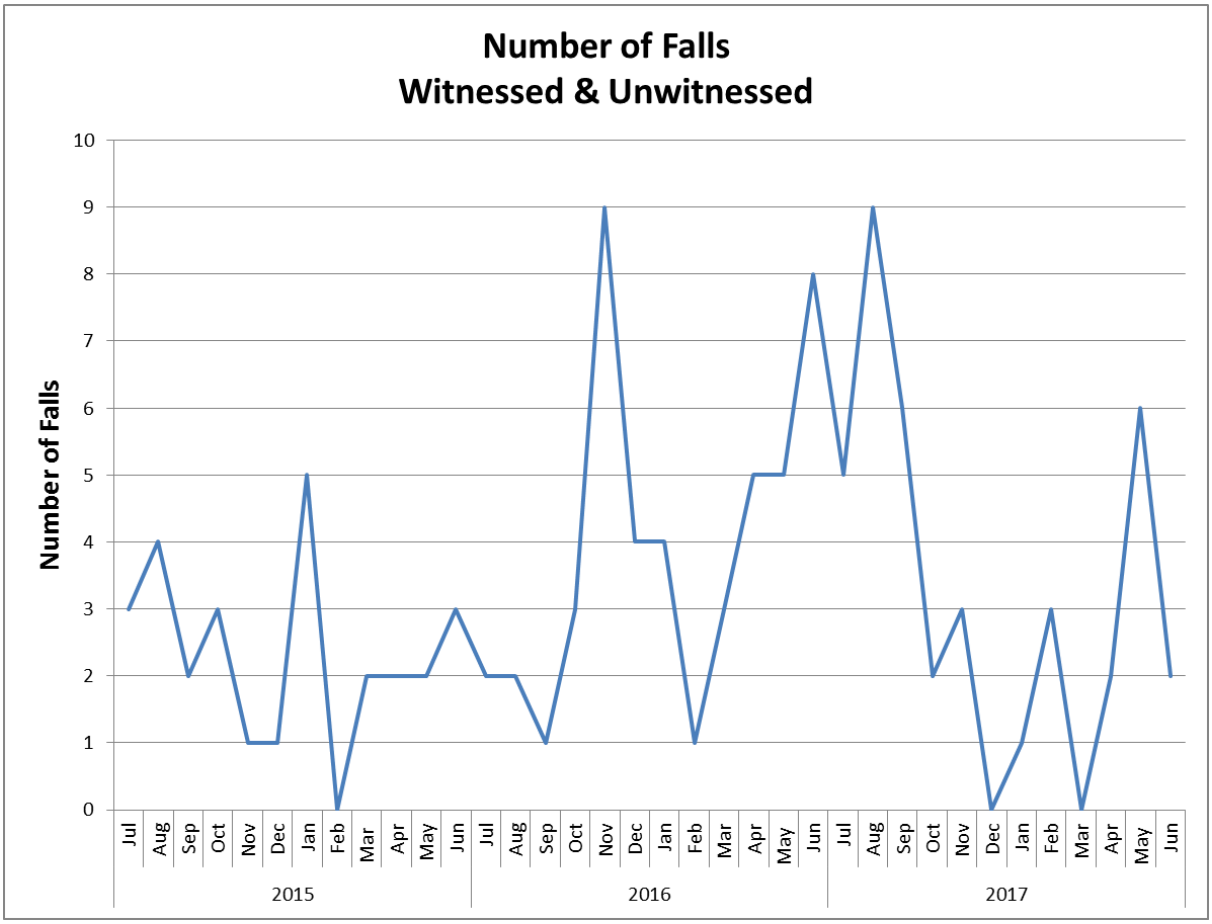
Fall Reduction Strategies

TJC PI.01.01. EP38 The hospital evaluates the effectiveness of all fall reduction activities including assessment, interventions and education.



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Fall Reduction Nursing Interventions — Carolyn Dimek, RN, MS

I. **Measure Name**: **Patient Falls - Establishing a Culture of Safety**
Measure Description: Up to 50% of hospitalized patients are at risk for falls, and almost half of those who fall suffer an injury (American Nurse Today, Special Supplement to American Nurse Today - Best Practices for Falls Reduction: A Practical Guide. Multiple authors, March 2011, 6. No 2). The objective of Nursing's Fall Performance Improvement measure is to ensure compliance with Nursing Procedure F-10 with the overall objective of ensuring that information is gathered about each patient for problem identification in order to ensure health and safety needs are met.
Type of Measure: Performance Improvement

All patient falls in 4Q2017	Falls risk assessment completed	Falls Progress Note 565 completed and in patient's medical record	Falls risk sticker on kardex	[redacted]
11 (Including 1 that did not meet definition)	Yes: 6 No: 1 N/A: 4	Yes: 11 No: 0 N/A: 0	Yes: 2 No: 0 N/A: 0 **	
Overall Compliance	**86%**	**100%**	**100%**	**94%**

**Question applicable for April 2017 only; the goal was met in April therefore this measure will no longer be reported on.

Data Analysis: There were 20 falls in 1Q2017 with an overall compliance of 87%, which was a 4% increase from 4Q2016. There were five falls, including two which did not meet definition, in 2Q2017 with an overall compliance of 100%; this is a 13% increase from 1Q2017. 3Q2017 shows four falls, including one that did not meet definition, with an overall compliance of 83%, a decrease of 17% from 2Q2017. Beginning this quarter, and throughout, nursing staff have received targeted education aimed at completion of fall documentation; we expect to see improvement in compliance with upcoming reporting. 4Q2017 shows 11 falls with 7 meeting definition of a fall. Overall compliance is 94% with the decrease produced by one "No" on the Fall Risk Assessment in April. The question, "Fall risk sticker on kardex" is removed from aggregation beginning May 2017 reporting; and the question, "Fall risk score of 6 or higher- Is problem 6.1 initiated (164 A & B)?" was removed from aggregation starting with November reporting; nursing staff documentation met the 100% goal for four consecutive months. These question will be evaluated by spot-check in 6 months to evaluate and ensure consistent and reliable documentation compliance.

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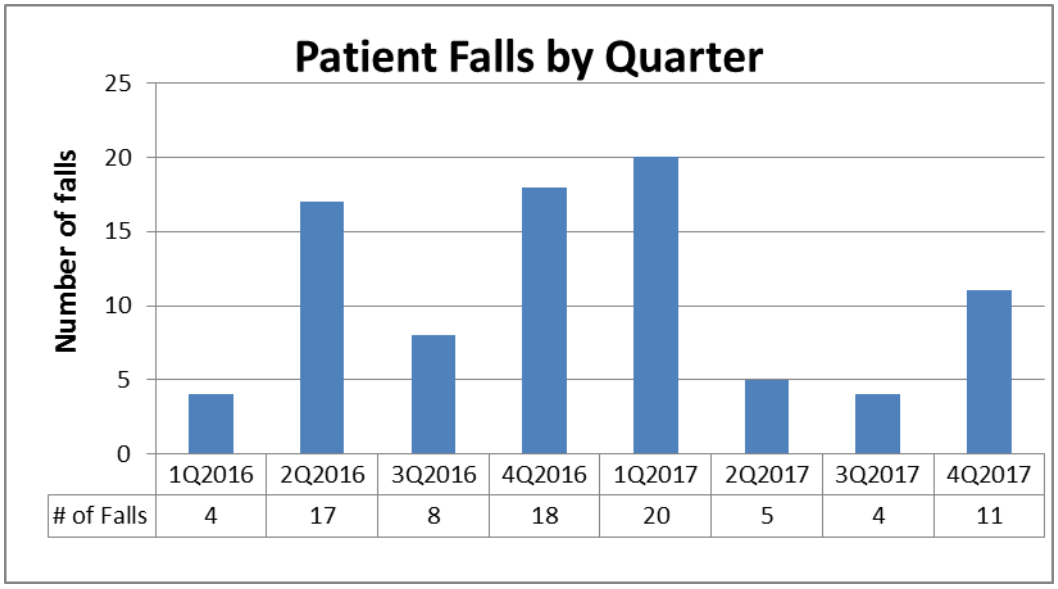

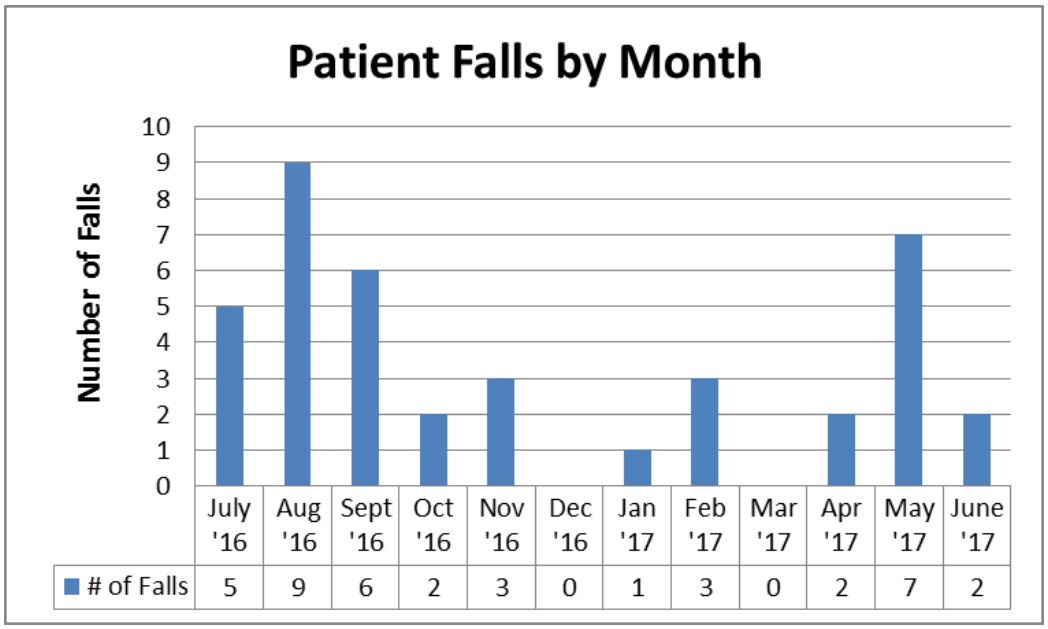

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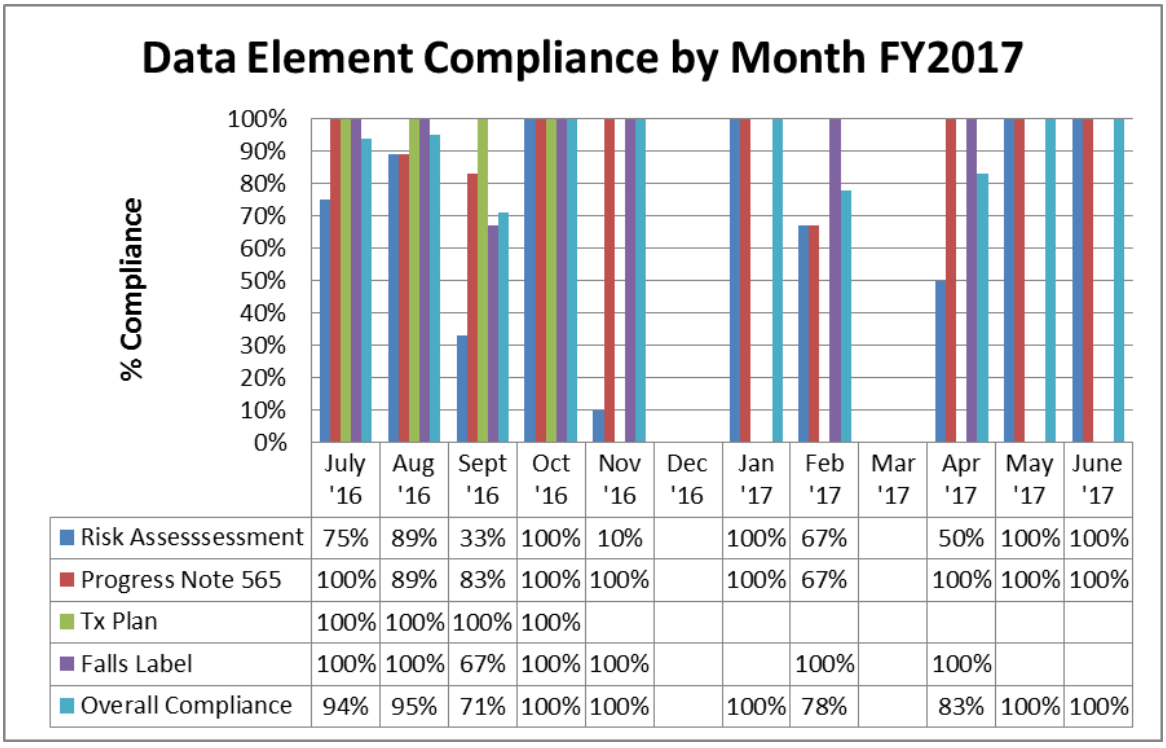
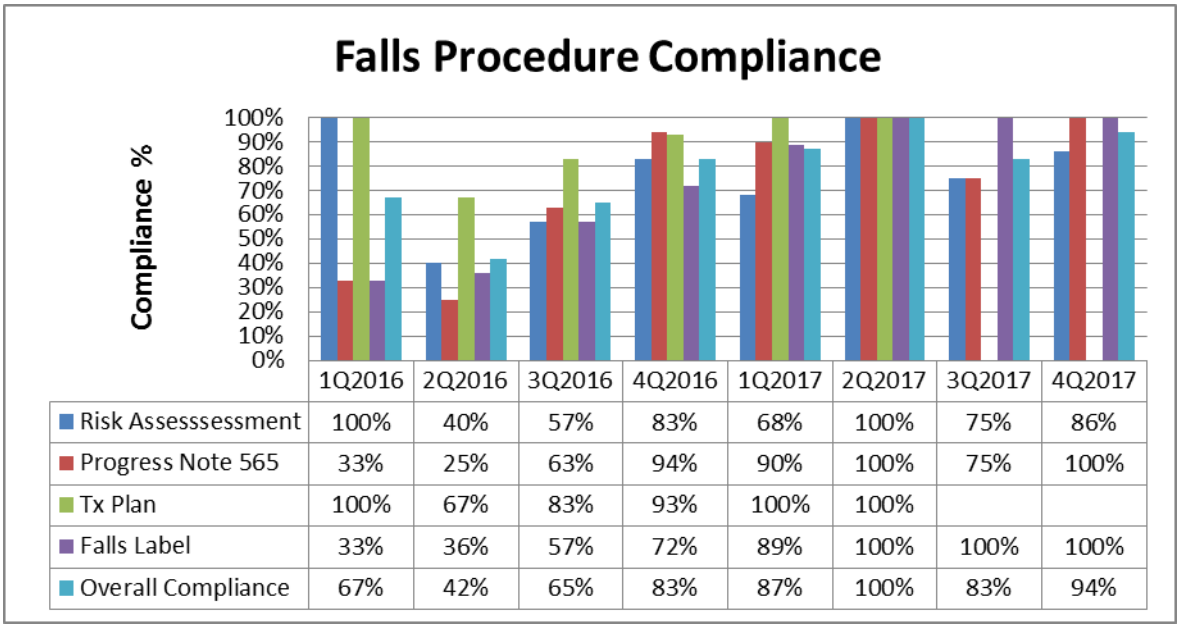


	July '16	Aug '16	Sept '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr '17	May '17	June '17
Risk Assesssessment	75%	89%	33%	100%	10%		100%	67%		50%	100%	100%
Progress Note 565	100%	89%	83%	100%	100%		100%	67%		100%	100%	100%
Tx Plan	100%	100%	100%	100%								
Falls Label	100%	100%	67%	100%	100%			100%		100%		
Overall Compliance	94%	95%	71%	100%	100%		100%	78%		83%	100%	100%



	1Q2016	2Q2016	3Q2016	4Q2016	1Q2017	2Q2017	3Q2017	4Q2017
Risk Assesssessment	100%	40%	57%	83%	68%	100%	75%	86%
Progress Note 565	33%	25%	63%	94%	90%	100%	75%	100%
Tx Plan	100%	67%	83%	93%	100%	100%		
Falls Label	33%	36%	57%	72%	89%	100%	100%	100%
Overall Compliance	67%	42%	65%	83%	87%	100%	83%	94%

Action Plan: Auditing Nurse Supervisor provides education to staff during auditing process. Nursing administration will continue to follow up and audit all falls.

JOINT COMMISSION

Pain Assessment **Carolyn Dimek, RN, MS**

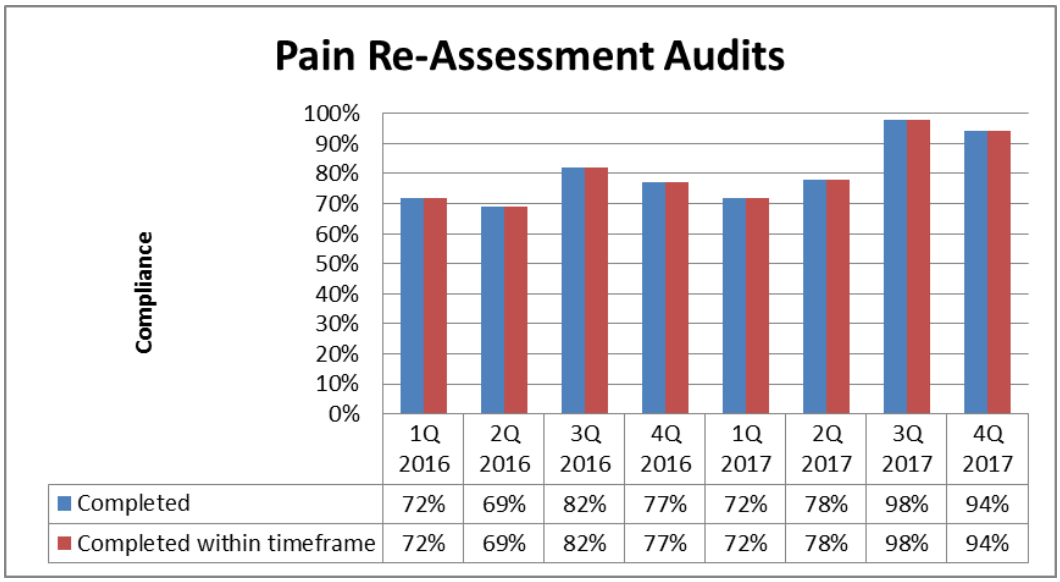
Pain Re-Assessment Audit Form

I. **Measure Name**: **Pain Reassessment Audit - Patient Recovery**
Measure Description: Untreated pain impairs an individual's ability to carry out their activities of daily living diminishing his or her quality of life; it can cause anxiety, fear, anger, or depression. Nursing acknowledges the impact of untreated pain on patient recovery and for this reason the objective of Nursing's Pain PI is to ensure patients are being assessed for pain and re-assessed if required. All MARs are reviewed for the month for pain reported and corresponding reassessment; the information is located on form #838 'Pain Flow Sheet.' The information is documented on the "Pain Assessment and Re-assessment Audit Form" for monthly and quarterly calculation. Audits were initiated in January 2013, January and February 2013 comprise the baseline data of 38%.
Type of Measure: Performance Improvement

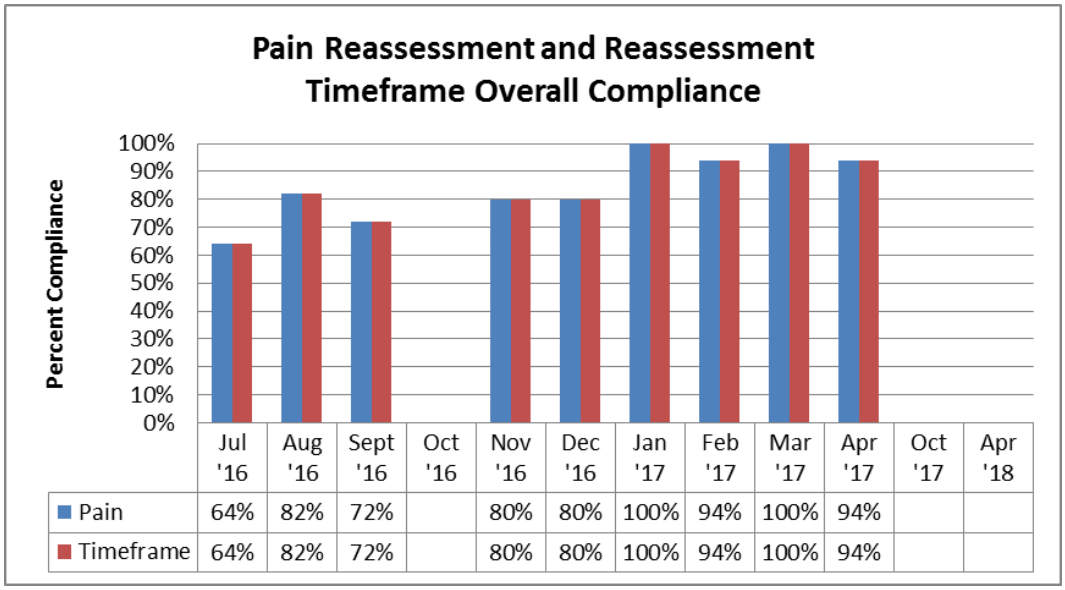
Results							
Target	**Data elements**	**Baseline Jan/Feb 2013**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
90% Compliance	Number of audits performed	89	116	87	118	41	**362**
	Number of patients with pain reported on Form 838	29	65	51	53	17	**186**
	Number of reassessments completed	11	47	40	52	16	**155**
	Number of reassessments reported within clinically appropriate timeframe (1-2 hours after oral medication and within 1 hour of intramuscular injection)	11	47	40	52	16	**155**
	Compliance with reassessment	**38%**	**72%**	**78%**	**98%**	**94%**	**86%**
	Compliance with reassessment timeframe	**38%**	**72%**	**78%**	**98%**	**94%**	**86%**

Data Analysis: 1Q2017 showed a 5% decrease from previous quarter with 72%, a 34% increase from baseline and matched the compliance rate from 1Q2016. 2Q2017 shows an increased compliance for both reassessment and reassessment timeframe with 78% compliance, 6% above 1Q2017 and 40% greater than baseline. 3Q2017 shows markedly improved compliance rates for reassessment and reassessment timeframe of 98%, 20% above last quarter and 60% above baseline. Individual month

totals were: January 100%, February 94%, and March 100%. 4Q2017 reveals goal attainment with four months in a row of overall compliance rates above 90%. April's compliance rate of 94% followed the three previous months in the 3Q2017 with individual rates noted above. Nursing will audit in six months (October, 2017), and pending continued compliance, will audit again at one year (April, 2018). At that time if the compliance rate continues at 90% or above, we will complete formal auditing. If the compliance rate is below 90%, we will resume formal auditing and reporting.



	1Q 2016	2Q 2016	3Q 2016	4Q 2016	1Q 2017	2Q 2017	3Q 2017	4Q 2017
Completed	72%	69%	82%	77%	72%	78%	98%	94%
Completed within timeframe	72%	69%	82%	77%	72%	78%	98%	94%



	Jul '16	Aug '16	Sept '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr '17	Oct '17	Apr '18
Pain	64%	82%	72%		80%	80%	100%	94%	100%	94%		
Timeframe	64%	82%	72%		80%	80%	100%	94%	100%	94%		

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Action Plan: Compliance has increased from 72% in the first quarter, to 78% in the second, and to 98% in the third. Nursing has exceeded the goal throughout this quarterly reporting period. Nursing has focused the last few months on the daily pain assessment and was able to move this into compliance. Since the analysis of the second quarter was revealed in late January, Nursing in February moved its initiative to addressing compliance with the pain re-assessment. The following corrective actions have been initiated and implemented to address pain re-assessment compliance:

- On 2/2/17, Nursing leadership met to discuss the compliance rate, current process for re-assessment, and barriers. Nursing leadership discussed implementing a flagging system, with charge nurse and Clinical Nurse Managers spot checking the forms for compliance and implementing med room hand-off between the oncoming and outgoing medication nurses.
    - *Hand-off has had a positive effect on the documentation process and compliance rates. The flagging system has not been implemented at this time.*
- On 2/2/17, an e-mail was distributed to all Nursing staff letting them know our performance improvement rates and informing them that focus and attention were necessary to get the pain re-assessment compliance rate up.
    - *Nurses' documentation rates have improved dramatically per data results.*
- On 2/15/17, an e-mail was distributed to the Nurse Managers reminding them to send an e-mail to all nurses regarding the expectation of performing hand-off in the medication room at the end of their shift and to also let them know that any missed documentation would result in progressive discipline.
- On 2/24/17, an email was distributed to the Nurse Managers and Charge Nurses on each unit with the expectation that the Director of Nursing and Performance Improvement Nurse would receive an email from each unit on Friday of every week describing the unit's adherence to pain documentation; if the compliance is below 90% an explanation is to be included as to the actions to remedy the situation.
    - This is a successful measure and is resulting in increased focus for improving documentation hospital-wide. Nursing staff are documenting increasingly well and are receiving positive feedback for noticeable improvements in practice.
    - On June 23 a reminder email was sent out to reinforce the importance and effectiveness of the Friday weekly email.

II. **Measure Name**: **Pain Audit Shift Assessment - Patient Recovery**

Measure Description: Untreated pain impairs an individual's ability to carry out their activities of daily living diminishing his or her quality of life; it can cause anxiety, fear, anger, or depression. Nursing acknowledges the impact of untreated pain on patient recovery and for this reason the objective of Nursing's Pain PI is to ensure patients are being assessed for pain and re-assessed if required. The procedure for Pain Audit Shift Assessment was updated to include a change in form; patient pain assessments are completed once daily. Documentation of patient pain at least every 24 hours is acceptable practice and meets regulations. The 2Q2017 measurements are comprised of November and December as October auditing was deferred during the revision process. Audits were initiated in January 2013, January and February 2013 comprise the baseline data of 33%.

Type of Measure: Performance Improvement

Results							
Target	**Data elements**	**Baseline Jan/Feb 2013**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
90% Compliance	Number of audits completed	36	106	84	107	119	**416**
	Number of audits having 1 shift assessment completed that assesses for the presence and intensity of pain within 24 hours	12	61	80	91	110	**342**
	Overall Compliance	**33%**	**58%**	**95%**	**85%**	**92%**	**82%**

Data Analysis: 1Q2017 showed an overall compliance of 58%, a 14% decrease from previous quarter and 25% increase from baseline. 2Q2017 showed an overall compliance of 95%, a 37% increase from first quarter's 58% and a significant 62% above baseline. 3Q2017 shows an overall compliance of 85%, a decrease of 10% from previous quarter, but 52% above baseline. January data showed a decrease to 66%, with February's compliance at 94%, and March's compliance at 95%. 4Q2017 shows a 7% increase from previous quarter to 92%, 2% above goal. FY2016 showed a 57% compliance rate, whereas FY2017 shows a pronounced improvement with a rate of 82%.

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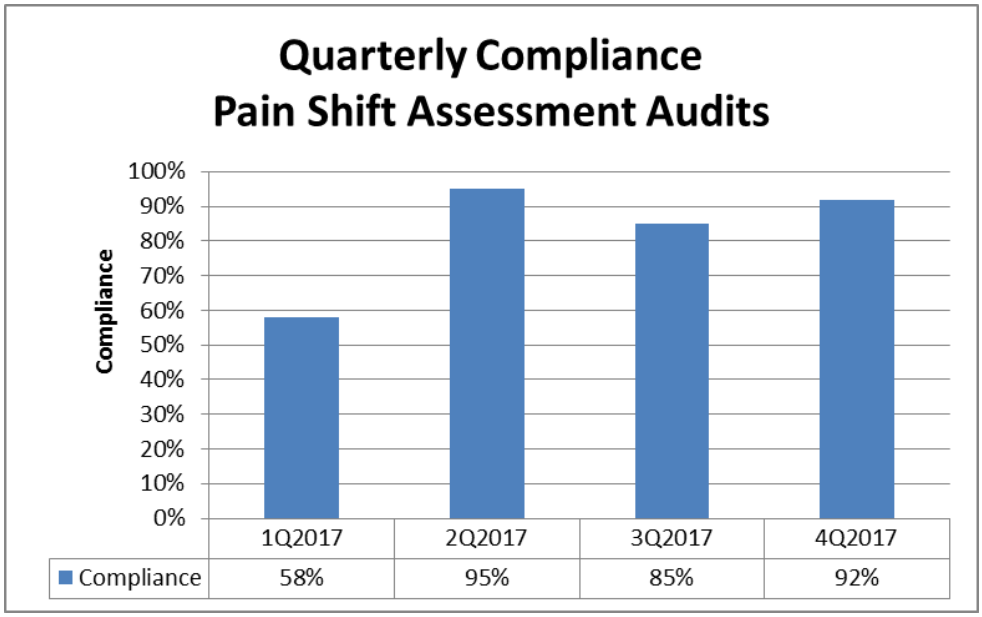
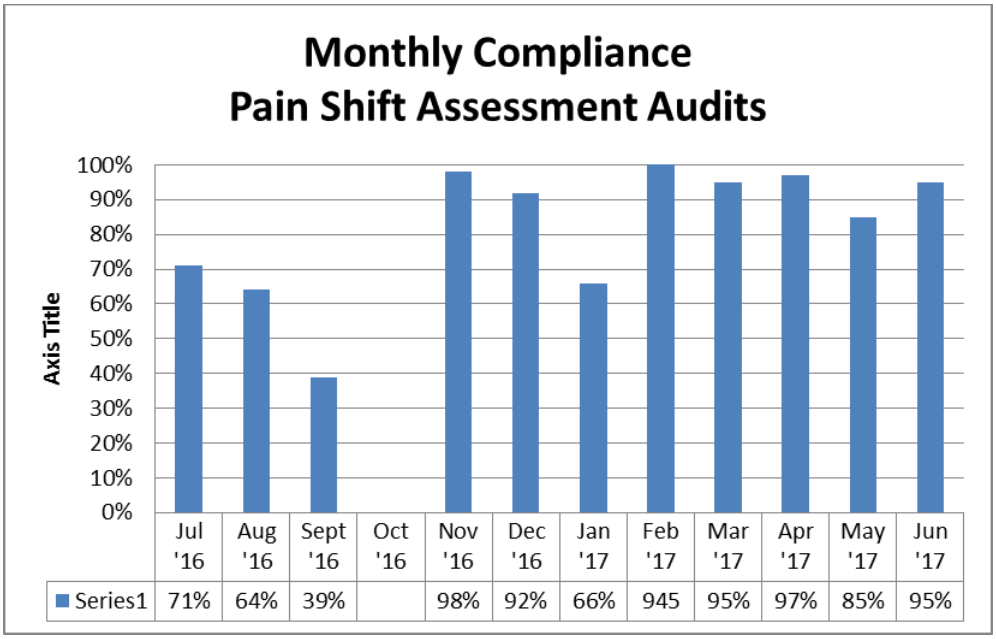




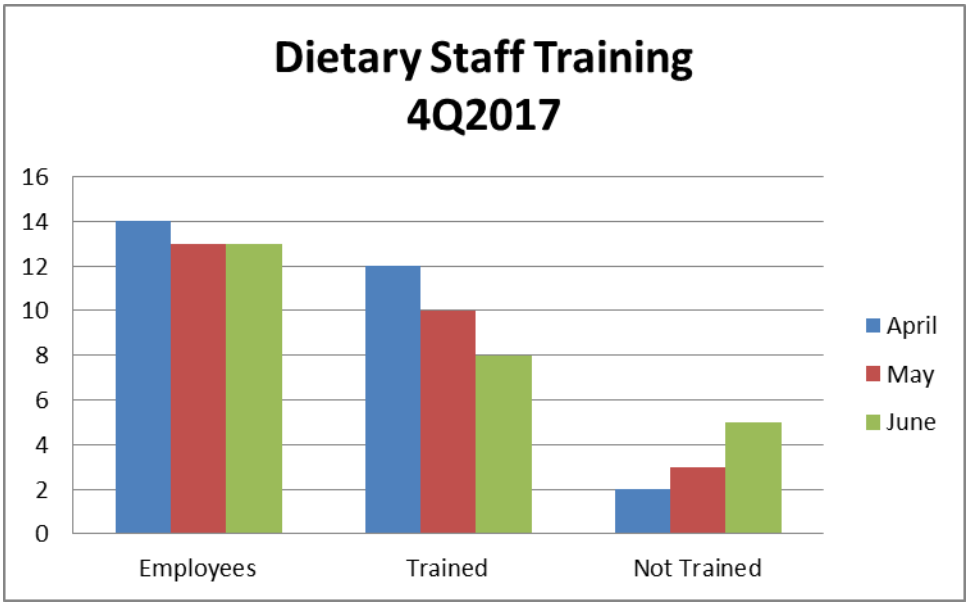
Action Plan: Nursing is below goal this quarter but has exceeded goal for the last two months. Nursing Administration will continue to collect data and monitor the process to ensure that pain is being assessed at least every 24 hours for every patient and documented. Clinical Nurse Managers will address staff members that are not completing these assessments. Clinical Nurse Managers or Charge Nurses will email Nursing Administration each week on Friday to report adherence to documentation procedure of pain.

STRATEGIC PERFORMANCE EXCELLENCE

Dietary — Bobbie Lindsey

I. **Measure Name**: **ServSafe Training**
Measure Description: ServSafe is a food and beverage safety training and certificate program administered by the National Restaurant Association
Type of Measure: Quality Assurance

Results						
	Baseline	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	1Q2017 93%	100%	100%	100%	100%	**100%**
Actual		93%	93%	93%	75%	**89%**



Data Analysis: The data indicates that we fell short of our goal of 100% certification by 11%.

Action Plan: Continue to offer the ServSafe class yearly, or as needed, to ensure that all staff remain certified. I would like to include other staff members in the hospital that handle food for patients.

Comments: A ServSafe class will be held this year for employees whose certificates are scheduled to expire and any new employees.

STRATEGIC PERFORMANCE EXCELLENCE

Facilities — Mark Faulkner

I. **Measure Name**: **Life Safety Standard Compliance for Above Ceiling Work**
Measure Description: Analyze compliance to Policy FP-9 involving Above Ceiling Work to verify conformance to life safety standards involving maintaining fire and smoke ratings of the space above the ceilings throughout the Hospital.
Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Number of ceiling inspections	1Q2017 100% (New Measure)	100%	100%	100%	100%	**100%**
Actual			100% 15/15	100% 18/18	100% 15/15	100% 15/15	**100% 63/63**

Methodology: The Director of Facilities (DOF) and the Plant Engineering Supervisor will perform physical checks of areas where above ceiling work is scheduled as well as other areas where above ceiling work is suspected to have occurred. Both approved and unapproved above ceiling work will be inspected and tracked separately and locations of the inspections noted on the tracking sheet. In accordance with Policy FP-9, 100% of scheduled above ceiling work will be inspected each month. In addition to scheduled checks, 15 unscheduled quarterly checks will be performed in areas as determined by the DOF and PES. The DOF will analyze the data monthly as to the success of the PI initiative

The numerator for both scheduled and unscheduled checks will be the total number of areas inspected with the denominator being the total number of scheduled and unscheduled inspections where no deficiency to the integrity of the rating is observed during the inspection. Scheduled and unscheduled above ceiling work inspections will be tracked separately. The performance percentage (performance ratio) for both scheduled and unscheduled above ceiling work inspections will be the numerator divided by the denominator.

Data Analysis: During the 4Q2017, 15 ceiling checks were performed. Of the 15 checks performed, all 15 were in compliance with life safety standards; therefore, the overall compliance rate for the quarter is 100%.

Action Plan: None needed at this time.

STRATEGIC PERFORMANCE EXCELLENCE

Health Information Management **Michelle Welch, RHIT**

Regulatory and Compliance Standards in Documentation

Ensuring Fiscal Responsibility in Documentation and Billing Practices

Indicator and Rationale for Selection	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Identification Data	100% 32/32	100% 25/25	100% 25/25	100% 24/24	**100% 106/106**
Medical History, including chief complaint; HPI; past, social & family hx., ROS, and physical exam w/in 24 hrs., conclusion and plan.	100% 32/32	100% 25/25	100% 25/25	100% 24/24	**100% 106/106**
Summary of patient's psychosocial needs as appropriate to the patients within 7 days of admission	94% 30/32	92% 23/25	92% 23/25	100% 24/24	**94% 100/106**
Psychiatric Evaluation in patient's record w/in 24 hrs. of admission	100% 32/32	100% 25/25	100% 25/25	96% 23/24	**100% 106/106**
Psychiatric Evaluation authenticated within 60 hours of admission	84% 27/32	92% 23/25	96% 24/25	79% 19/24	**88% 93/106**
Physician (TO/VO w/in 72 hrs.)	91% 162/179	88% 142/161	88% 135/154	92% 122/133	**89% 561/627**
Evidence of appropriate informed consent	93% 26/28 4 declined	100% 25/25	96% 24/25	100% 20/20 4 declined	**97% 95/98 8 declined**
Clinical observations including the results of therapy.	100% 32/32	100% 25/25	100% 25/25	100% 24/24	**100% 106/106**
Nursing discharge Progress Note with time of discharge departure	100% 32/32	96% 24/25	100% 25/25	92% 92/94	**98% 173/176**
Consultation reports, when applicable	100% 10/10 22=N/A	100% 9/9 16=N/A	100% 10/10 15=N/A	100% 8/8	**100% 37/37 53=N/A**
Advance Directive Status on admission and SW follow up after	94% 30/32	96% 25/25	100% 25/25	92% 22/24	**96% 102/106**
Notice of Privacy	100% 32/32	100% 25/25	100% 25/25	96% 23/24	**100% 106/106**
Chart Completion w/in 30 days of discharge date/discharge summary completed within 30 days	97% 31/32	100% 25/25	100% 25/25	100% 24/24	**99% 105/106**
Discharge Packet sent to follow up provider within 24 hours of discharge.	100% 32/32	84% 21/25	80% 20/25	92% 22/24	**90% 95/106**

STRATEGIC PERFORMANCE EXCELLENCE

Human Resources — Tamra Hanson

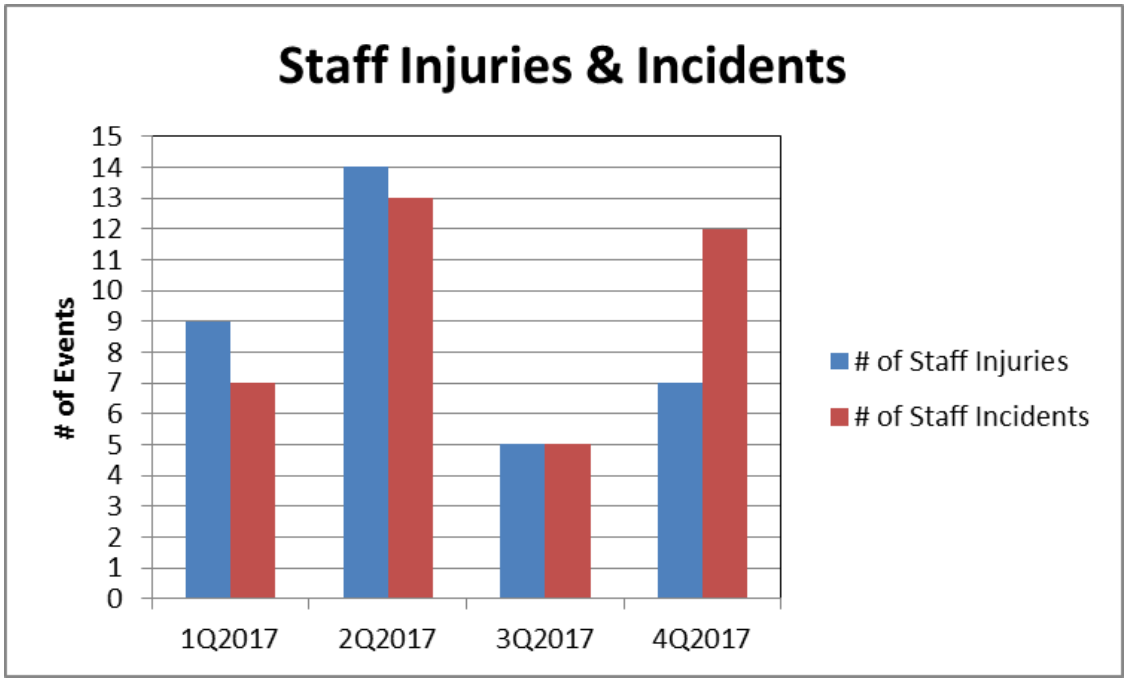
I. **Measure Name**: **Employee work-related injuries (require treatment) and incidents (do not require treatment).**
Measure Description: Staff safety is central to DDPC. While staff safety events may not be completely eliminated, events can be reduced by reviewing trends related to injuries.
Type of Measure: Performance Improvement

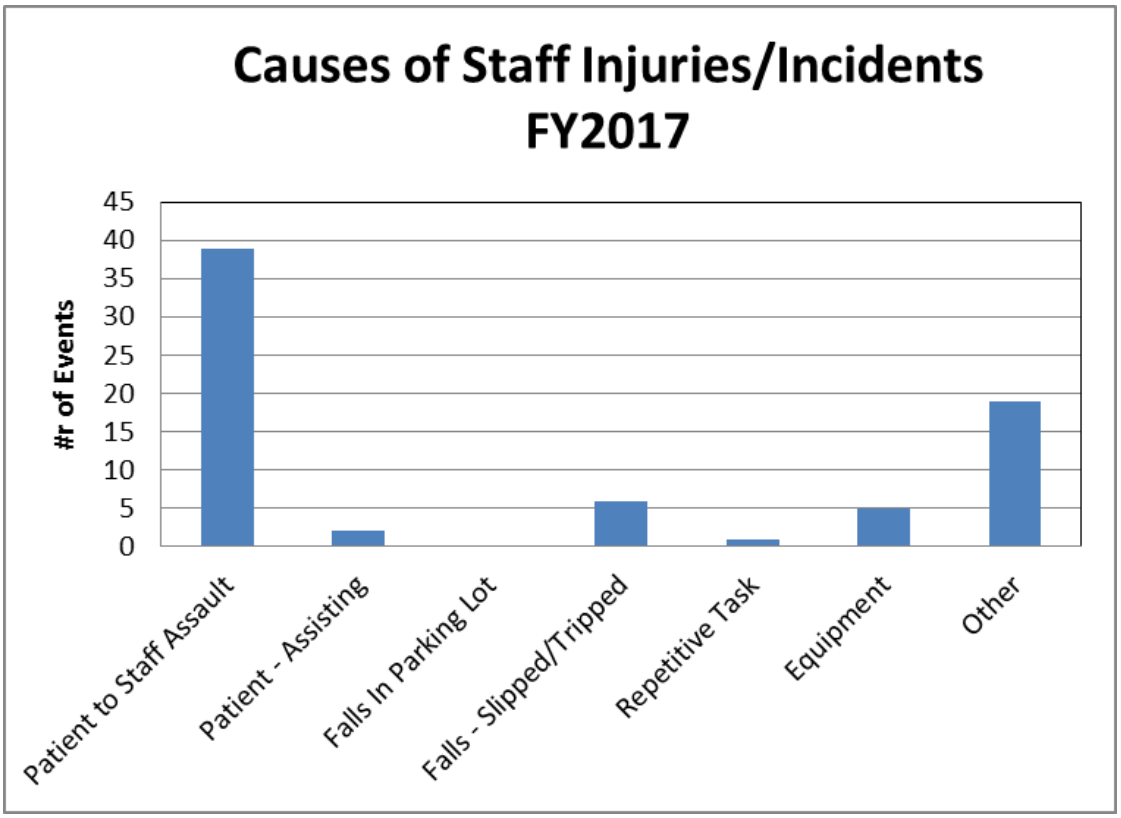
Results					
	1Q2017 (Baseline)	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
# of Staff Injuries	9	14	5	7	**35**
# of Staff Incidents	7	13	5	12	**37**

Data Analysis: In the 4Q2017, DDPC had 19 staff injuries/incidents; this is an increase of 9 injuries/incidents from 3Q2017's total of ten. Nineteen injuries/incidents consisted of ten patient-to-staff, three equipment, and six other. The number of patient to staff injuries increased from three in 3Q2017 to ten in 4Q2017.

Action Plan: A baseline has been established. We will start reporting at IPEC to inform leadership of staff safety events and trending data to look for opportunities to reduce the likelihood of injuries in the future.

STRATEGIC PERFORMANCE EXCELLENCE





STRATEGIC PERFORMANCE EXCELLENCE

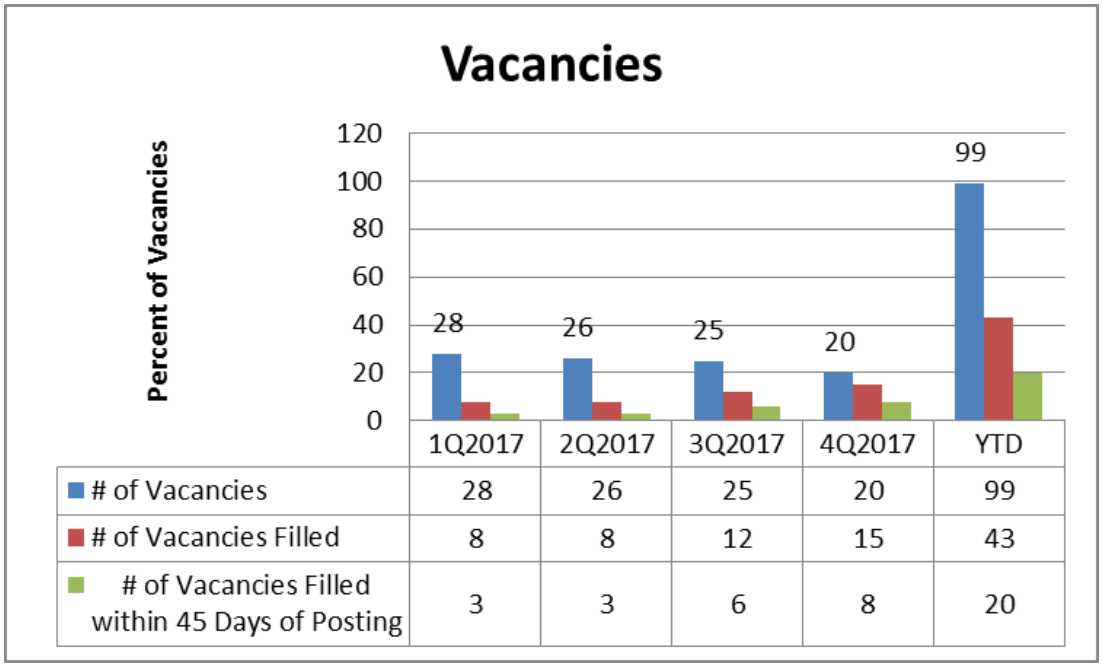
II. **Measure Name**: **Vacancies filled within 45 days of posting.**
Measure Description: The hospital will maintain an adequate workforce to maintain safety and provide therapeutic care for patients.
Type of Measure: Performance Improvement

	Results					
	Baseline	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	FY2016 Average	100%	100%	100%	100%	**100%**
Vacancy Rate %	15%	14%	13%	12%	10%	**12%**
# Vacancies Posted	14	8	8	12	15	**43**
# Vacancies Filled Within 45 Days	6	3	3	6	8	**20**
% Posted & Filled Within 45 Days	40%	38%	38%	50%	53%	**47%**

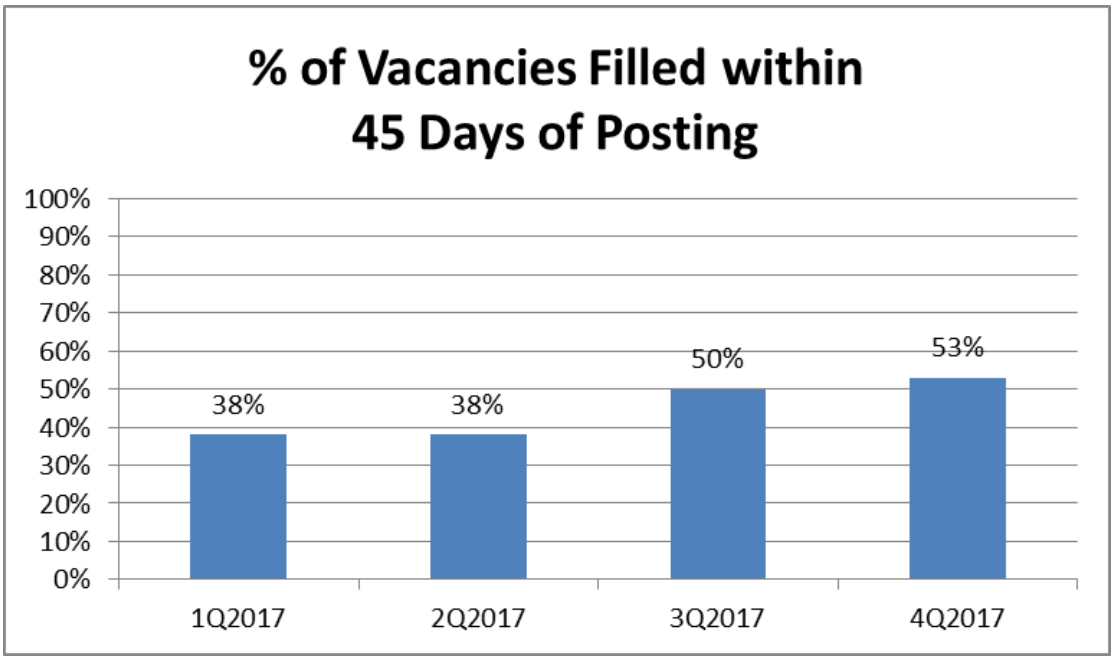
Data Analysis: This is new data collection in an effort to reduce extended time periods of vacant positions

Action Plan: Increase percentage rate of filled quarterly posted vacancies within 45 days of posting.

STRATEGIC PERFORMANCE EXCELLENCE



	1Q2017	2Q2017	3Q2017	4Q2017	YTD
# of Vacancies	28	26	25	20	99
# of Vacancies Filled	8	8	12	15	43
# of Vacancies Filled within 45 Days of Posting	3	3	6	8	20



STRATEGIC PERFORMANCE EXCELLENCE

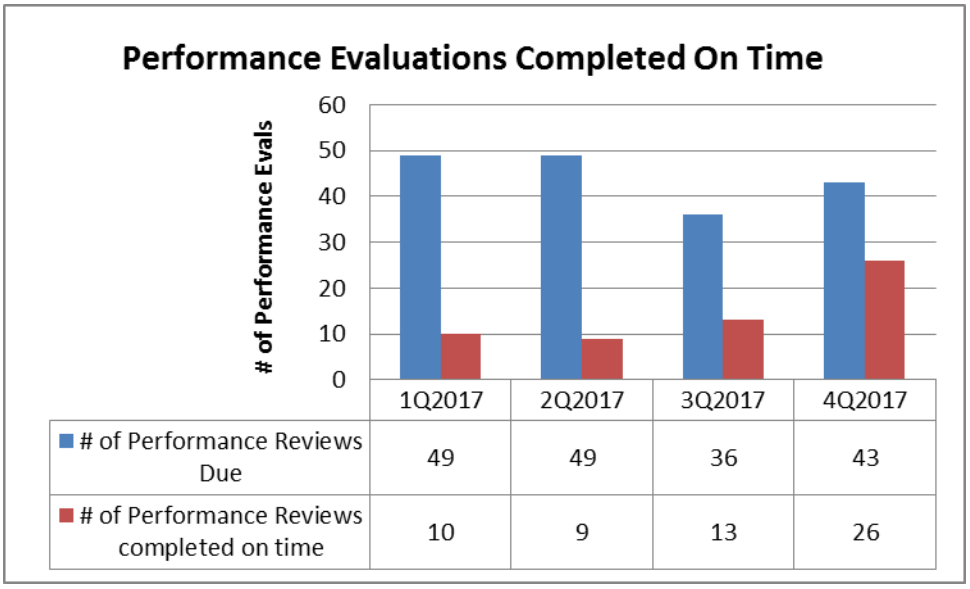
III. **Measure Name: Performance Evaluations completed by due date.**
Measure Description: DDPC evaluates staff based on performance expectations that reflect their job responsibilities. This evaluation is documented in the HR Personnel File by is due date.
Type of Measure: Performance Improvement

Results						
	Baseline	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Monthly Average FY2016	100%	100%	100%	100%	**100%**
# Due	43	49	49	36	43	**177**
# Completed on Time	17	10	9	13	26	**58**
% Completed on Time	**38%**	**20%**	**18%**	**36%**	**60%**	**33%**

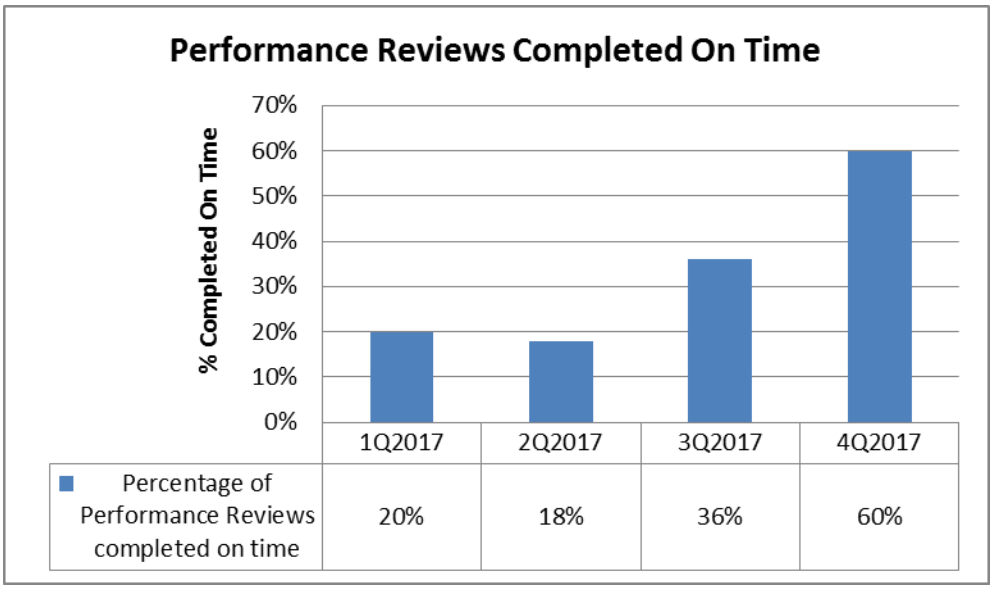
Data Analysis: The FY 2016 average percentage of performance evaluations submitted by the due date was at 38%; the 4QFY17 is at 60%, a 22% increase from the average baseline.

Action Plan: This is new data collection. We will start reporting at IPEC so that managers are aware of the data. This will hopefully continue increasing our compliance rates. Reminders are sent by Human Resources to supervisors one month prior to the employee evaluation due date and then every week until they are received.

STRATEGIC PERFORMANCE EXCELLENCE



	1Q2017	2Q2017	3Q2017	4Q2017
# of Performance Reviews Due	49	49	36	43
# of Performance Reviews completed on time	10	9	13	26



	1Q2017	2Q2017	3Q2017	4Q2017
Percentage of Performance Reviews completed on time	20%	18%	36%	60%

STRATEGIC PERFORMANCE EXCELLENCE

Infection Control — Lisa Tomilson, RN

I. Measure Name: Hospital Acquired Infections

Measure Description: Surveillance data will continue to be gathered on the following hospital acquired infections: UTI, URI, LRI, and Skin. Data will be reviewed monthly and reported quarterly.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target: 0 HAI	# of HAI per quarter	FY 2012 0 HAI	1 HAI	0 HAI	0 HAI	0 HAI	**1 HAI**

Data Analysis: There was no hospital acquired infections for 4Q2017, and only one hospital acquired infection for FY2017.

Action Plan: Continue to Monitor

H. A. Infections	FY 2015	FY 2016	FY 2017
1st Quarter H.A.I. Rate	0	0	1
2nd Quarter H.A.I. Rate	0	0	0
3rd Quarter H.A.I. Rate	0	1	0
4th Quarter H.A.I. Rate	0	0	0
Average H.A. Infection Rate	0	0.25	0.25

FY 2014-2017 Hospital Acquired Infections

Type of Infection	1Q 2015	1Q 2016	1Q 2017	2Q 2015	2Q 2016	2Q 2017	3Q 2015	3Q 2016	3Q 2017	4Q 2015	4Q 2016	4Q 2017
UTI	0	0	0	0	0	0	0	0	0	0	0	0
URI	0	0	0	0	0	0	0	0	0	0	0	0
LRI	0	0	1	0	0	0	0	0	0	0	0	0
Skin	0	0	0	0	0	0	0	1	0	0	0	0
Totals	0	0	0	0	0	0	0	1	0	0	0	0
Infection Rate	0	0	0.26	0	0	0	0	0.28	0	0	0	0

STRATEGIC PERFORMANCE EXCELLENCE

II. **Measure Name: Patient & Family Education on Hand Hygiene/Cough Etiquette**
Measure Description: Prior to discharge, a questionnaire will be distributed to each patient that includes the following questions:

D1: I received information on how to stay healthy by washing my hands

D2: I received information on how to cover my cough or sneeze to prevent the spread of illness

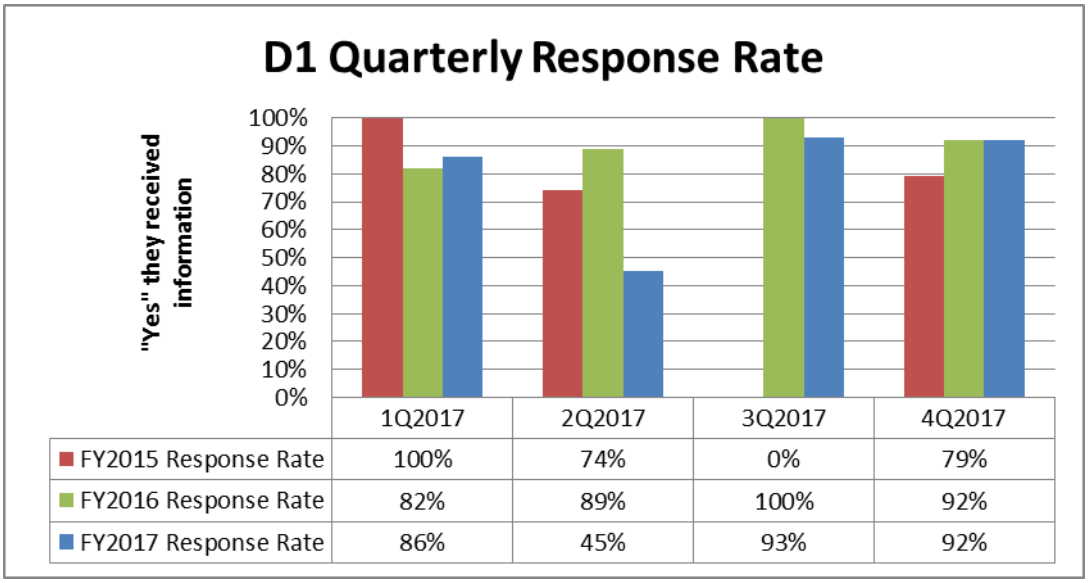
Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target: D1 90%	Quarterly response rate "agree/strongly agree" for D1 & D2 is set at 90%	2012: D1 response rate: 80%	86%	45%	93%	92%	**79%**
Target: D2 90%		2012: D2 response rate: 80%	86%	45%	89%	83%	**76%**

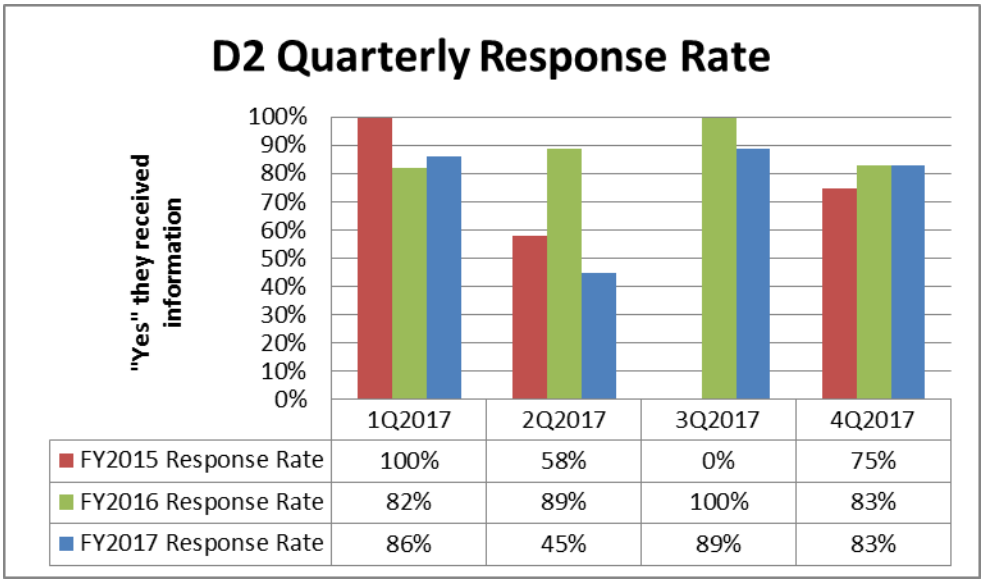
Data Analysis: 4Q2017 response rate for question D1 was 92%, a decrease of 1% from the previous quarter. 4Q2017 response rate for question D2 was 83%, a decrease of 7% from the previous quarter.

Action Plan: For FY2017, the goal has been increased to 90% compliance rate. Infection Control Nurse will increase presence on the units, offering education to patients and ensuring that Purell is being offered/encouraged at meal times.

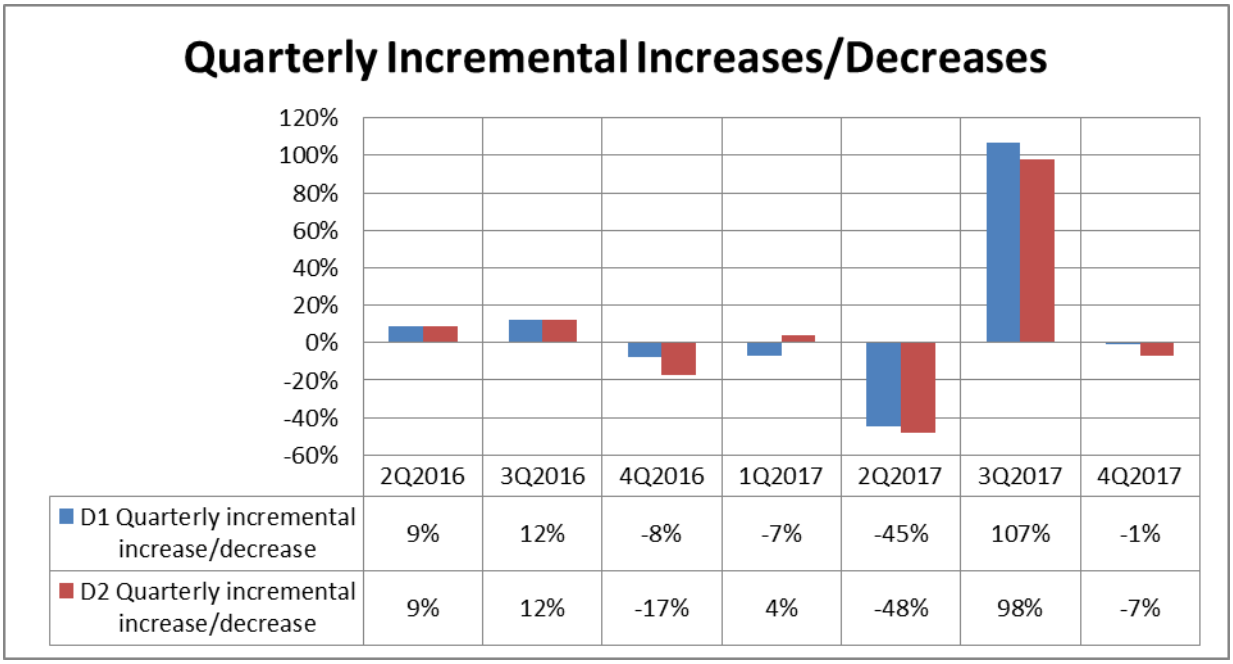
STRATEGIC PERFORMANCE EXCELLENCE



	1Q2017	2Q2017	3Q2017	4Q2017
FY2015 Response Rate	100%	74%	0%	79%
FY2016 Response Rate	82%	89%	100%	92%
FY2017 Response Rate	86%	45%	93%	92%



	1Q2017	2Q2017	3Q2017	4Q2017
FY2015 Response Rate	100%	58%	0%	75%
FY2016 Response Rate	82%	89%	100%	83%
FY2017 Response Rate	86%	45%	89%	83%



III. Measure Name: Healthcare Worker (HCW) Hand Hygiene

Measure Description: HCW hand hygiene is being monitored on each unit with a minimum of 10 "direct observations" during a 24 hour period per month. This is currently the "gold star" and the most reliable method for assessing adherence rates.

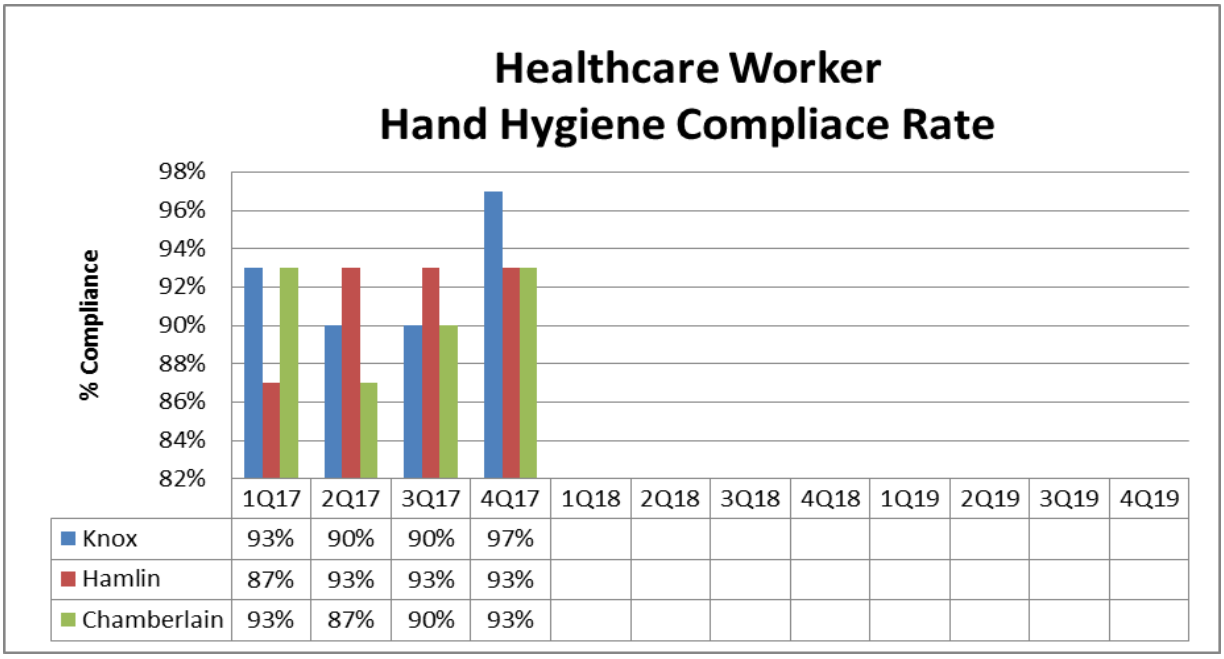
Type of Measure: Performance Improvement

		Results					
	Unit	**Baseline 1Q2017**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target: sustained level of compliance that approaches 90%	HCW hand hygiene compliance rate per unit per quarter	Knox: 93%	93%	90%	90%	97%	**93%**
		Hamlin: 87%	87%	93%	93%	93%	**92%**
		Chamberlain: 93%	93%	87%	90%	93%	**91%**

Data Analysis: In the 4Q2017, Knox's compliance rate was 97%, and increase of 8% from the previous quarter; Hamlin's compliance rate was 93%, no change from the previous quarter; and Chamberlain's compliance rate was 93%, an increase of 3% from the previous quarter. Examples for why Hand Hygiene was excluded: negligence, hand sanitizer unavailable, emergent situations, etc.

Action Plan: Continue to monitor HCW hand hygiene compliance per CDC guidelines. Educate staff on how missed opportunities could be corrected.

STRATEGIC PERFORMANCE EXCELLENCE



IV. Measure Name: Influenza Immunizations

Measure Description: The standard goal is to have a sustained level of compliance that approaches and achieves the 90% compliance rate established in the National Flu Initiative for 2020. Employee flu vaccination compliance is measured annually**.**

Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Target: 90%	Percent of employees who receive the flu vaccination	FY 2015 81%	69%	75%			

Data Analysis: For FY2017 the employee flu vaccination compliance rate was 75%, a 9% increase in compliance over last fiscal year.

Action Plan: Continue to educate staff and promote influenza vaccinations.

STRATEGIC PERFORMANCE EXCELLENCE

Medical Staff — Dr. Michelle Gardner

I. Measure Name: Restraint Documentation

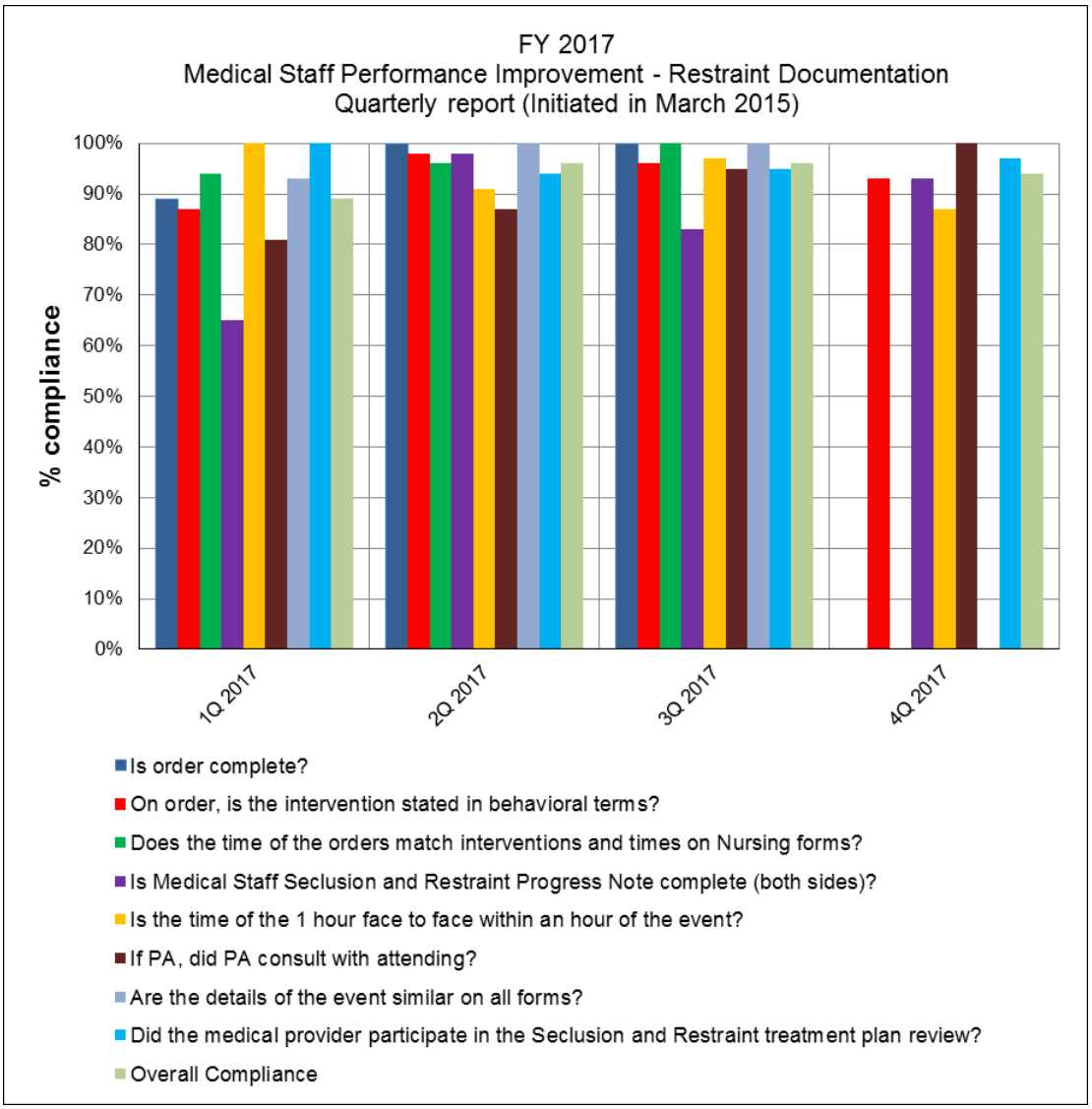
Measure Description: Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusion/restraint have been met. Documentation is critical for patient care/safety, as it validates the care that was provided.

Type of Measure: Performance Improvement

Results							
Target	**Restraints**	**Baseline (March 2015)**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD 2017**
100%	Total Restraints	12	39	53	27	25	**144**
	Is order complete?	N/A	89%	100%	100%		
	On order, is the intervention stated in behavioral terms?	100%	87%	98%	96%	93%	**94%**
	Does the time of the orders match interventions and times on Nursing forms?	N/A	94%	96%	100%		
	Is Medical Staff Seclusion and Restraint Progress Note complete (both sides)?	100%	65%	98%	83%	93%	**85%**
	Is the time of the 1 hour face to face within an hour of the event?	100%	100%	91%	97%	87%	**94%**
	If PA, did PA consult with attending?	100%	81%	87%	95%	100%	**91%**
	Are the details of the event similar on all forms?	100%	93%	100%	100%		
	Did the medical provider participate in the Seclusion and Restraint treatment plan review?	N/A	100%	94%	95%	97%	**97%**
	Overall Compliance	**100%**	**89%**	**96%**	**96%**	**94%**	**94%**

Data Analysis: There were 25 restraints in the 4Q2017 with an overall compliance of 94%, a 2% decrease in compliance from 96% in 3Q2017. Question: "If PA on Form #409, did PA consult with attending?" has been removed from aggregation and is not calculated in June reporting. Medical staff documentation met the 100% goal for four consecutive months. It will be evaluated by spot-check in six months to evaluate and ensure consistent and reliable documentation compliance. The following questions were previously removed from aggregation: "Is the order complete?", "Does the time of the orders match interventions and times on nursing forms?", and "Are details of event similar on all

forms?", as medical staff met the 100% goal for four consecutive months, and they will be evaluated by spot check in six months to evaluate and ensure consistent and reliable documentation compliance.



Goal: 100% Compliance with Medical Staff Documentation

Action Plan: The plan is to continue to monitor compliance with the above data elements, discuss, and address non-compliance in documentation and procedure with medical staff.

II. Measure Name: Seclusion Documentation

Measure Description: Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusion/restraint have been met. Documentation is critical for patient care/safety, as it validates the care that was provided.

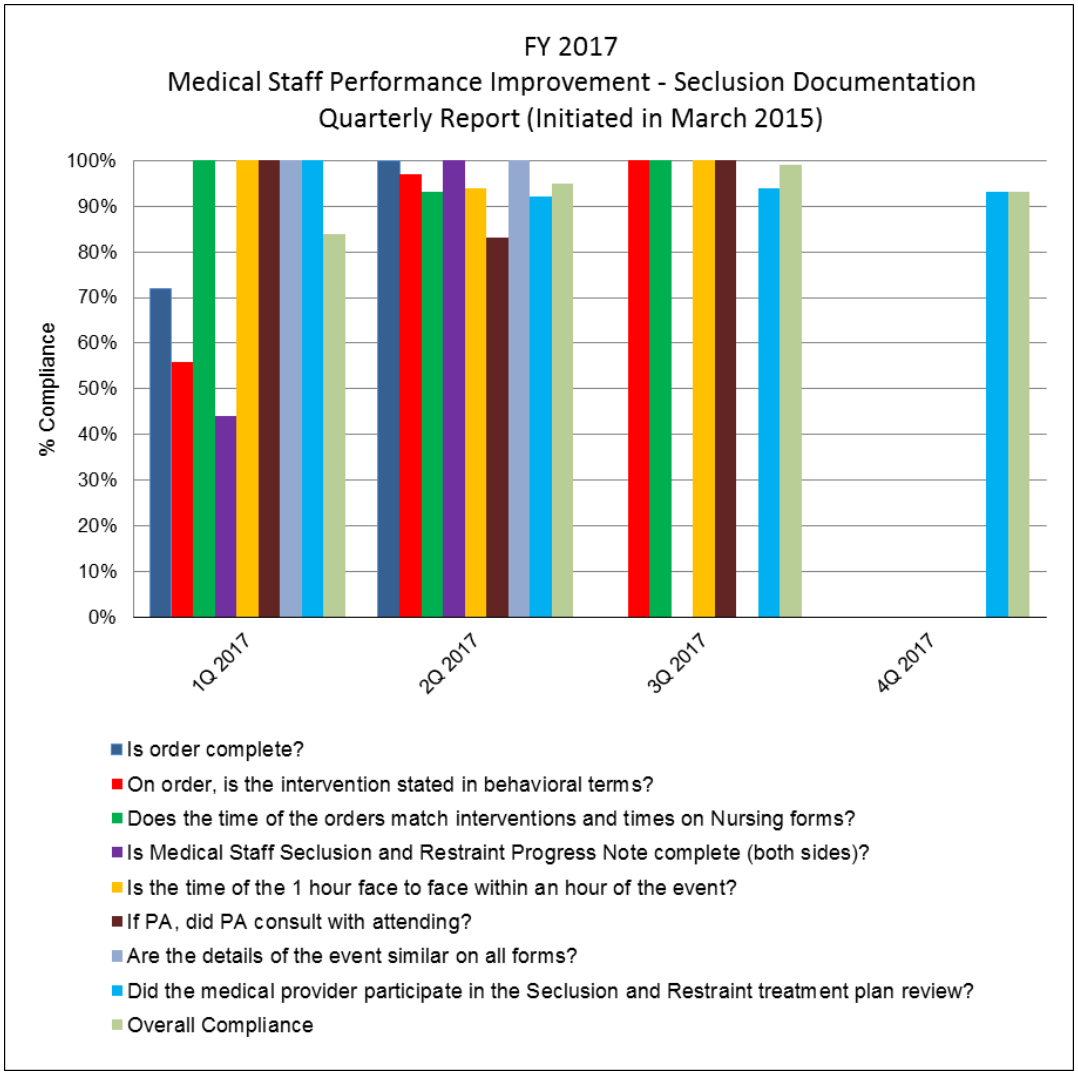
Type of Measure: Performance Improvement

Results							
	Seclusions	**Baseline (March 2015)**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD 2017**
Target 100%	Total Seclusions	7	12	27	9	12	**60**
	Is order complete?	N/A	72%	100%			
	On order, is the intervention stated in behavioral terms?	92%	56%	97%	100%		
	Does the time of the orders match interventions and times on Nursing forms?	N/A	100%	93%	100%		
	Is Medical Staff Seclusion and Restraint Progress Note complete (both sides)?	100%	44%	100%			
	Is the time of the 1 hour face to face within an hour of the event?	100%	100%	94%	100%		
	If PA, did PA consult with attending?	92%	100%	83%	100%		
	Are the details of the event similar on all forms?	100%	100%	100%			
	Did the medical provider participate in the Seclusion and Restraint treatment plan review?	N/A	100%	92%	94%	93%	**95%**
	Overall Compliance	**96%**	**84%**	**95%**	**99%**	**93%**	**93%**

Data Analysis: There were 12 seclusion events in the 4Q2017 with an overall compliance of 93% compared to 3Q2017's 9 events and 99% compliance. All seclusion events were locked door. Questions: "Is the time of the 1 hour face to face within an hour of the event?" and "If PA on Form #409, did PA consult with attending?" were removed from aggregation and not calculated beginning with April reporting. Medical staff documentation met the 100% goal for four consecutive months. These questions will be evaluated by spot-check in 6 months to evaluate and ensure consistent and reliable documentation compliance.

STRATEGIC PERFORMANCE EXCELLENCE

The following questions were previously removed from aggregation. Medical staff documentation met the 100% goal for four consecutive months. These questions will be evaluated by spot-check in 6 months to evaluate and ensure consistent and reliable documentation compliance. "Is medical staff's S & R progress note complete?", "Are details of event similar on all forms?", "On order, is the intervention stated in behavioral terms?", "Does the time of the orders match interventions and times on Nursing forms?", "Is order complete?", "Is Form #409 Medical Staff Seclusion and Restraint Progress Note complete?", and "Are details of event similar on all forms without discrepancies, #408 #409 and Order sheets."



Goal: 100% Compliance with Medical Staff Documentation

Action Plan: The plan is to continue to monitor compliance with the above data elements, discuss, and address non-compliance in documentation and procedure with medical staff.

III. Measure Name: All elements of a medication order are complete.

Measure Description: To promote safe medication ordering by defining the required elements of a complete medication order. CMS 482.23 (c) Medications Drugs must be administered in response to an order from a practitioner, or on the basis of a standing order which is appropriately authenticated subsequently by a practitioner. In accordance with standard practice, all practitioner orders for the administration of drugs and biologicals must include at least the following:

- Name of the patient;
- Age and weight of the patients, or other dose calculation requirements, when applicable;
- Date and time of the order;
- Drug name;
- Dose, frequency, and route;
- Exact strength or concentration, when applicable;
- Quantity and/or duration, when applicable;
- Specific instructions for use, when applicable; and
- Name of the prescriber.

Type of Measure: Performance Improvement

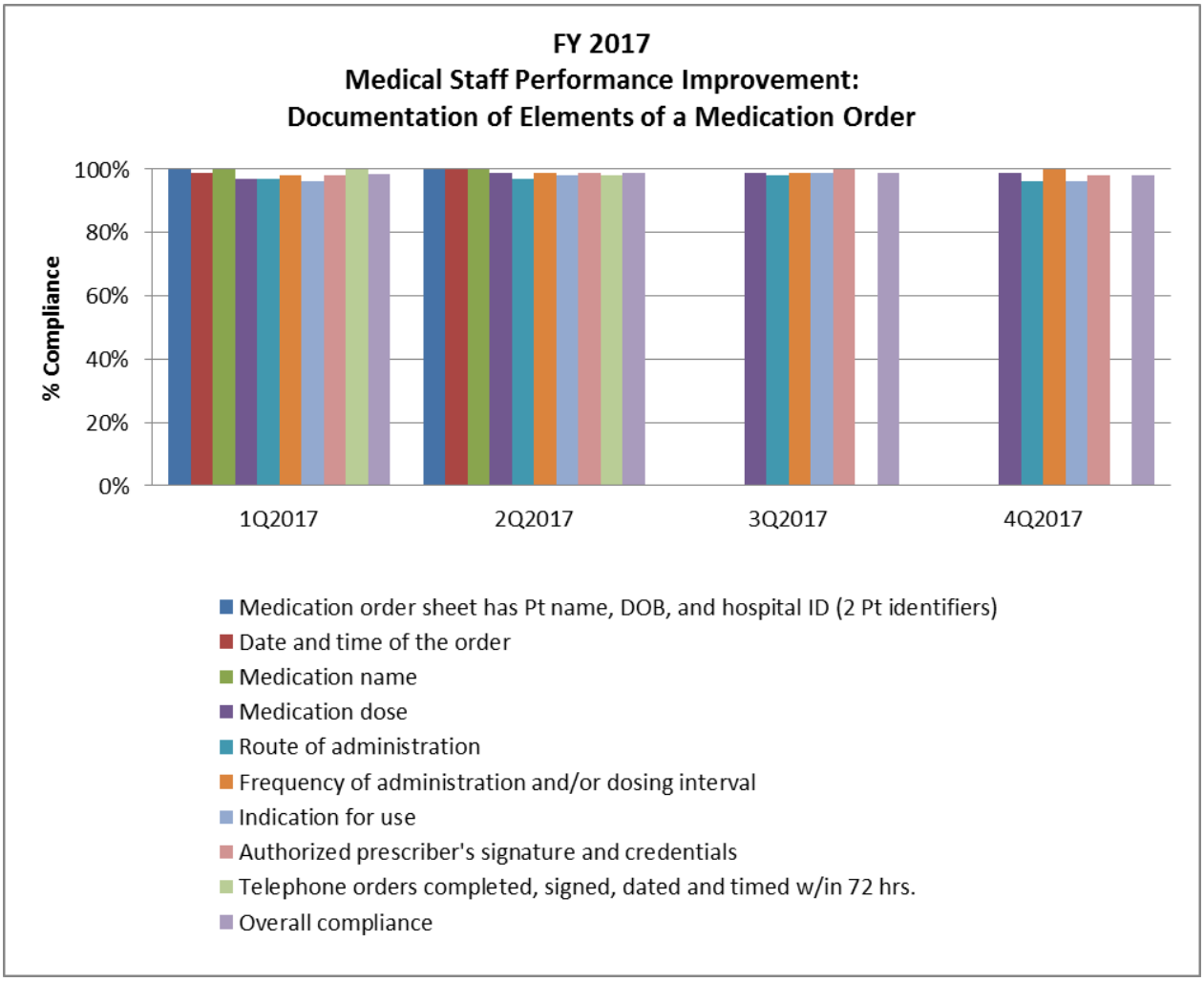
Methodology: (Medical Staff Performance Improvement with Medical Records providing data). The Medical Director will review data provided by Medical Record monthly for compliance with all elements of a medication order. Ten to 15 medication orders per unit will be reviewed monthly by unit clerks for compliance with the elements of a medication order using and audit tool with a check of box of “yes” or “no”. The denominator will be all orders within the audit month. The numerator will be the elements of the order that are within compliance.

Goal: The goal is to have a combined compliance score of **100%** with each element of a medication order for 4 consecutive months. The threshold is set at **90%**. The results of the audits will be reported to the IPEC committee quarterly and the Advisory board.

STRATEGIC PERFORMANCE EXCELLENCE

Data Elements	Baseline 4Q2016	1Q2017	2Q2017	3Q2017	4Q2017	Total Compliance
# of Medication orders reviewed	245	258	238	274	238	**1008**
Medication order sheet has patient name, DOB and hospital number ID (2 patient identifiers)?	100%	100%	100%			
Date and time of the order	99%	99%	100%			
Medication name	99%	100%	100%			
Medication dose	96%	97%	99%	99%	99%	**99%**
Route of administration	94%	97%	97%	98%	96%	**97%**
Frequency of administration and/or dosing interval	92%	98%	99%	99%	100%	**99%**
Indication for use	90%	96%	98%	99%	96%	**97%**
Authorized prescribers signature and credentials	97%	98%	99%	100%	98%	**99%**
Telephone orders completed, signed, dated and timed w/in 72 hr.	97%	100%	98%			
Overall Compliance	**96%**	**98%**	**99%**	**99%**	**98%**	**99%**

STRATEGIC PERFORMANCE EXCELLENCE



Data Analysis: Overall compliance for 4Q2017 is 98%, a 1% decrease from 3Q2017 and 2Q2017's 99%. No further elements have met goal within the quarter, but three do have the opportunity to meet goal within the 1QFY2018. The blacked-out portions are elements which have met goal in previous quarters. Medication dose after improvement has been steady at 99% for three quarters and was 100% for the months May and June. Route of administration continues to fluctuate above 95% and finishes this quarter at 96. Frequency of administration and/or dosing interval is 100% this quarter. Authorized prescribers signature and credentials is 98%, down 2% from 100% last quarter, but did have 100% for June.

Action Plan: Information will be disseminated monthly to Medical Staff. The Clinical Director will review and address compliance issues with Medical Staff.

STRATEGIC PERFORMANCE EXCELLENCE

Nursing — Carolyn Dimek, RN, MS

I. Measure Name: Restraint Audits – Patient Safety

Measure Description: Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusion/restraint have been met. Documentation is critical for patient care/safety, as it validates the care that was provided. The audits were initiated January of 2015.

Type of Measure: Performance Improvement

Results							
Target	**Data Elements**	**Baseline 4Q2016**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
100%	# of Events	35	39	53	27	25	**119**
	1. Each order obtained within 15 minutes of the intervention?	83%	96%	100%			
	4. Is Form 408 Nursing Seclusion/Restraint Progress Note complete?	95%	83%	95%	93%	90%	**90%**
	5. On Form 408 Nursing Seclusion/Restraint Progress Note, Form 470 Nursing Assessment Protocol for Seclusion and Restraint, and Physician Orders do times match for interventions initiated and time of events?	97%	94%	96%	100%		
	9. Are details of event similar on all forms without discrepancies 408, 409, and Order sheets?	97%	93%	100%	100%		
	10. Is Form 470 Nursing Assessment Protocol for Seclusion and Restraint completed?	96%	100%	100%			
	11. On Form # 407RN 2 Hour Seclusion and Restraint Breaks 2 hour breaks are completed at appropriate intervals and signed by RN?	N/A	N/A	100%	100%	N/A	**100%**

STRATEGIC PERFORMANCE EXCELLENCE

Target	Data Elements	Baseline 4Q2016	1Q 2017	2Q 2017	3Q 2017	4Q 2017	YTD
100%	12. On Form #407RN 2 Hour Seclusion and Restraint Breaks is time ended for S/R completed and signed by RN	N/A	N/A	75%	100%	N/A	**88%**
	13. On Form #407 Seclusion & Restraint Monitoring and Assessment 15 minute checks are completed at appropriate intervals, with Pt's behavior documented in behavioral terms as it pertains to release criteria, times, dated, and initialed by staff?	N/A	N/A	100%	100%	N/A	**100%**
	14. On Form #407 Seclusion & Restraint Monitoring and Assessment did each staff member that initialed 15 minute checks complete last page of form with signature and title?	N/A	N/A	75%	0%	N/A	**36%**
	15. Were debriefings DB1 & DB2 completed at appropriate times?	99%	89%	96%	99%	100%	**96%**
	16. Is patient debriefing in the chart?	89%	93%	94%	99%	100%	**97%**
	19. Was Form 470 TX Focused Treatment Plan Review completed within 24 hours?	88%	91%	92%	95%	93%	**93%**
	Overall Compliance	**93%**	**92%**	**94%**	**89%**	**96%**	**93%**

Data Analysis: Baseline data compiled August 2015, with updates to Seclusion and Restraint procedure, forms, and audit tool occurring since that time. The 1Q2017 showed a compliance rate of 92%, a 1% decrease from 4Q2016 and a 4% increase from baseline. Four elements increased and 4 elements decreased with negligible statistical impact. The 2Q2017 shows an overall compliance of 94%, a 2% increase from 1Q2017 and 6% above baseline. Seven elements increased while none decreased. The 3Q2017 shows an 89% overall compliance, a 5% decrease from 2Q2017 and 3% above baseline. Four elements increased, three remain the same at 100% and two decreased; there is a 0 noted which brings the overall compliance down dramatically; this is because there was only one mechanical restraint and the documentation was lacking in that one instance. 4Q2017 shows an increase and the highest compliance rating of the fiscal year at 96%; an increase of 6% from last quarter; two elements increased and two elements decreased. There were 25 restraint events this quarter down from 27 last quarter.

There were no mechanical restraint events; all events were manual holds. Numerous restraint events can be contributed to same-patient manual holds over the course of the quarter.

- Knox had no events during this quarter.
- Hamlin had five events this quarter, all in April, with a compliance rate of 100%.
- Chamberlain had 20 events this quarter with a compliance rate of 94%.

Nursing documentation was extracted and separated from Medical Staff documentation except for one data element, #9 "Are details of event similar on all forms without discrepancies, #408, #409 and Order sheets" as this reflects equivalent documentation responsibilities, prior to goal accomplishment.

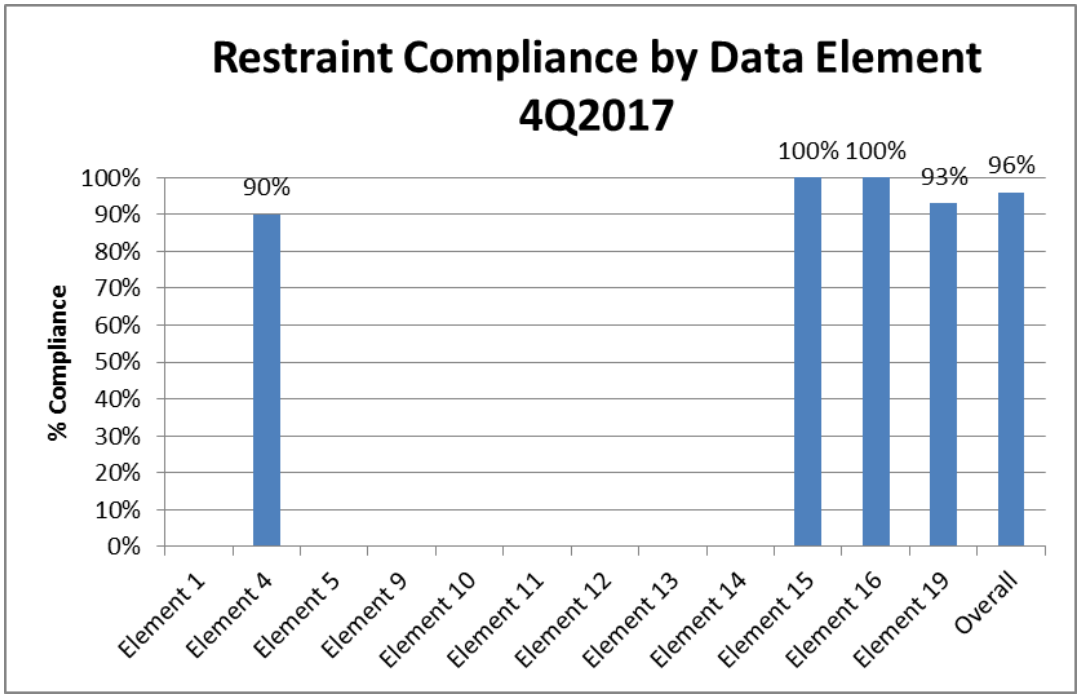
Nursing staff met the 100% goal for four consecutive months for two questions; these will no longer be included in reporting after this 4Q2017 report. These questions will be evaluated by spot-check in six months to evaluate and ensure consistent and reliable documentation compliance. The questions (#15), "*Were debriefings DB1 and DB2 completed at appropriate times?* and (#16), "Is patient debriefing in the chart?"

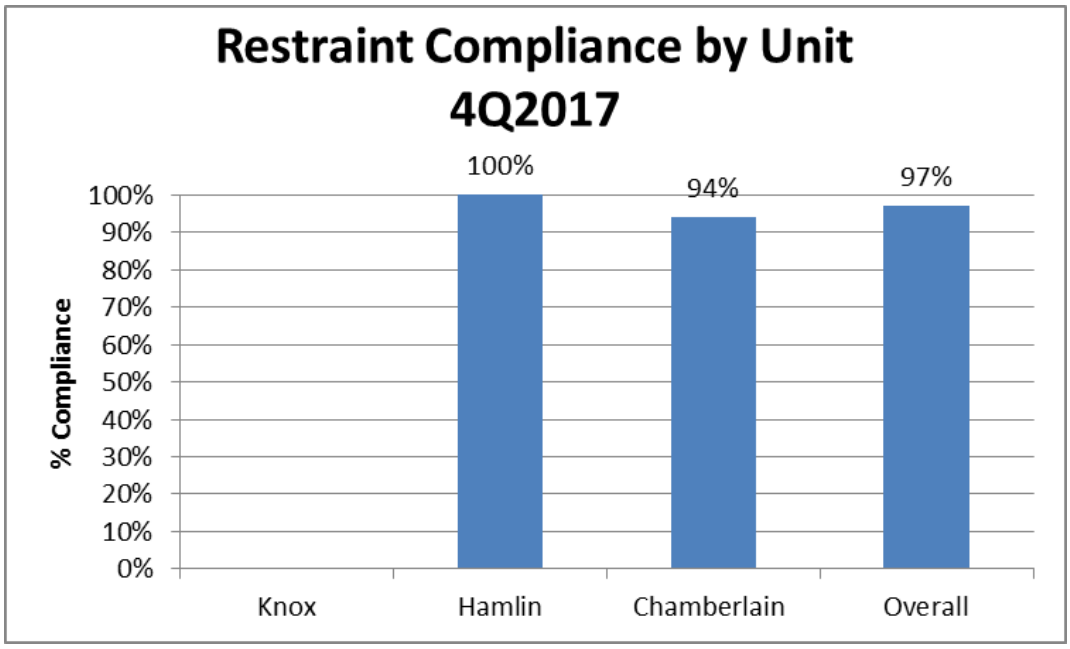
Nursing staff met the 100% goal for four consecutive months for two questions; these will no longer be included in reporting after this 3Q2017 report. The questions (#9), "*Are details of event similar on all forms without discrepancies $408, #409, and order sheet?* and (#5), *"On Form #408 Nursing Seclusion/Restraint progress Note, Form #470 Nursing Assessment Protocol for Seclusion and Restraint, and Physician Orders do times match for intervention initiated and time of events?"* These questions will be evaluated by spot-check in six months to evaluate and ensure consistent and reliable documentation compliance.

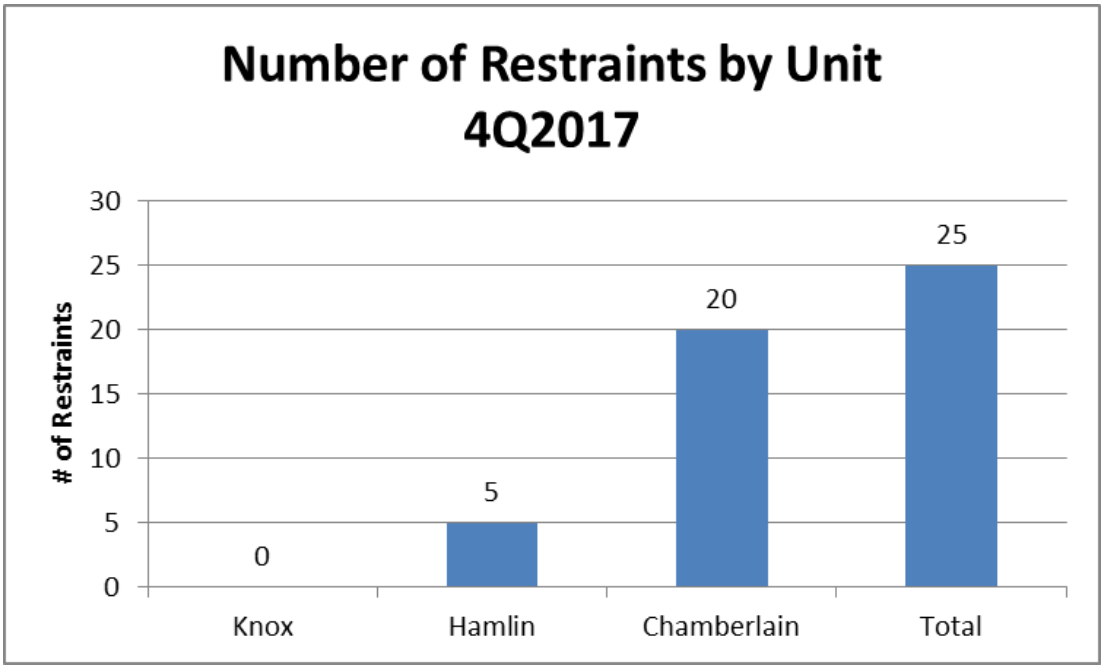
Nursing staff met the 100% goal for four consecutive months for the following two questions; these will no longer be included in reporting after the 2Q2017 report. The questions (#10), "*Is Form # 470 Nursing Assessment Protocol for Seclusion and Restraint completed?"* This question will be evaluated by spot-check in six months to evaluate and ensure consistent and reliable documentation compliance. The question (#1), "Each order obtained within 15 minutes of the intervention?" was removed from aggregate reporting for December; Nursing documentation met the 100% goal for four consecutive months with November reporting. This question will be evaluated by spot-check in six months to evaluate and ensure consistent and reliable documentation compliance.

"Was legal guardian or agent made aware of time of debriefing?" and "Did legal guardian or agent attend debriefing?" have been removed from aggregate data and are reported via numbers only in monthly reporting- this began with February '16 reporting.

STRATEGIC PERFORMANCE EXCELLENCE







Action Plan: Nursing staff shows improvement in documentation, but remains below goal. Nursing will continue to audit the documentation of patient restraints on a monthly basis and re-evaluate quarterly. Nursing will compare data gathered from Meditech reporting to ensure all coercive events are captured. There is a possibility that prior to beginning this cross-check in December 2015 events were not captured for data collection.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: **Seclusion Documentation**

Measure Description: Proper documentation is the only way to demonstrate and provide a record that the clinical criteria and assessments for seclusion/restraint have been met. Documentation is critical for patient care/safety, as it validates the care that was provided.

Type of Measure: Performance Improvement

Results							
Target	**Data Elements**	**Baseline 4Q2016**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
100% Compliance	# of Events	13	10	27	9	12	**58**
	1. Each order obtained within 15 minutes of the intervention?	91%	89%	100%			
	4. Is form #408 Nursing Seclusion/Restraint Progress Note complete?	82%	89%	100%			
	5. On Form #408 Nursing Seclusion/Restraint Progress Note, Form #470 Nursing Assessment Protocol for Seclusion and Restraint, and Physician Orders do times match for interventions initiated and time of events?	100%	100%				
	9. Are details of event similar on all forms without discrepancies #408, #409, and Order sheets?	100%	100%	100%			
	10. Is Form # 470 Nursing Assessment Protocol for Seclusion and Restraint completed?	88%	100%	100%			
	11. On Form # 407RN 2 Hour Seclusion and Restraint Breaks 2 hour breaks are completed at appropriate intervals and signed by RN?	84%	100%	97%	100%		

STRATEGIC PERFORMANCE EXCELLENCE

Results							
Target	**Data Elements**	**Baseline 4Q2016**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
100% Compliance	12. On Form #407RN 2 Hour Seclusion and Restraint Breaks is time ended for S/R completed and signed by RN	59%	89%	86%	100%	100%	94%
	13. On Form #407 Seclusion & Restraint Monitoring and Assessment 15 minute checks are completed at appropriate intervals, with Pt's behavior documented in behavioral terms as it pertains to release criteria, times, dated, and initialed by staff?	94%	72%	96%	100%		
	14. On Form #407 Seclusion & Restraint Monitoring and Assessment did each staff member that initialed 15 minute checks complete last page of form with signature and title?	61%	68%	82%	89%	81%	80%
	15. Were debriefings DB1 & DB2 completed at appropriate times?	100%	83%	97%	100%		
	16. Is patient debriefing in the chart?	75%	100%	95%	100%		
	19. Was Form # 470 TX Focused Treatment Plan Review completed within 24 hours?	86%	83%	97%	94%	87%	90%
	Overall Compliance	**85%**	**89%**	**95%**	**98%**	**89%**	**93%**

Data Analysis: Baseline data compiled August 2015, with updates to Seclusion and Restraint procedure, forms, and audit tool occurring since that time. The 4Q2017 shows an overall compliance of 89%, a decrease of 9% from last quarter's 98%. There were 12 seclusion events, all locked door, with numerous events involving the same patient. The 3Q2017 shows an overall compliance of 98%, an improvement of 3% from 2Q2017 and 18% above baseline; six elements increased and three decreased. The 2Q2017 shows an overall compliance of 95%, a 6% increase from 1Q2017 and 10% above baseline; six elements

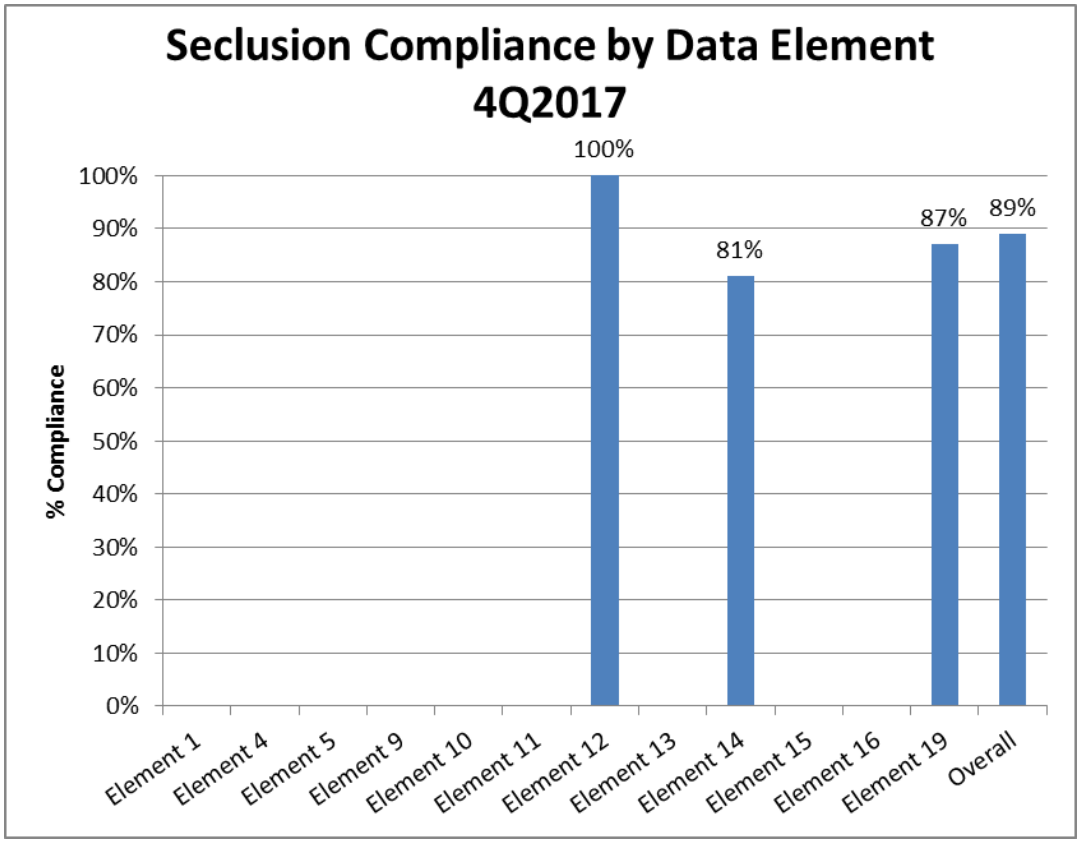
increased and three decreased. The 1Q2017 showed a compliance rate of 89%, a 4% increase from 4Q2016/baseline; six elements increased, four elements decreased, and two elements stayed the same.

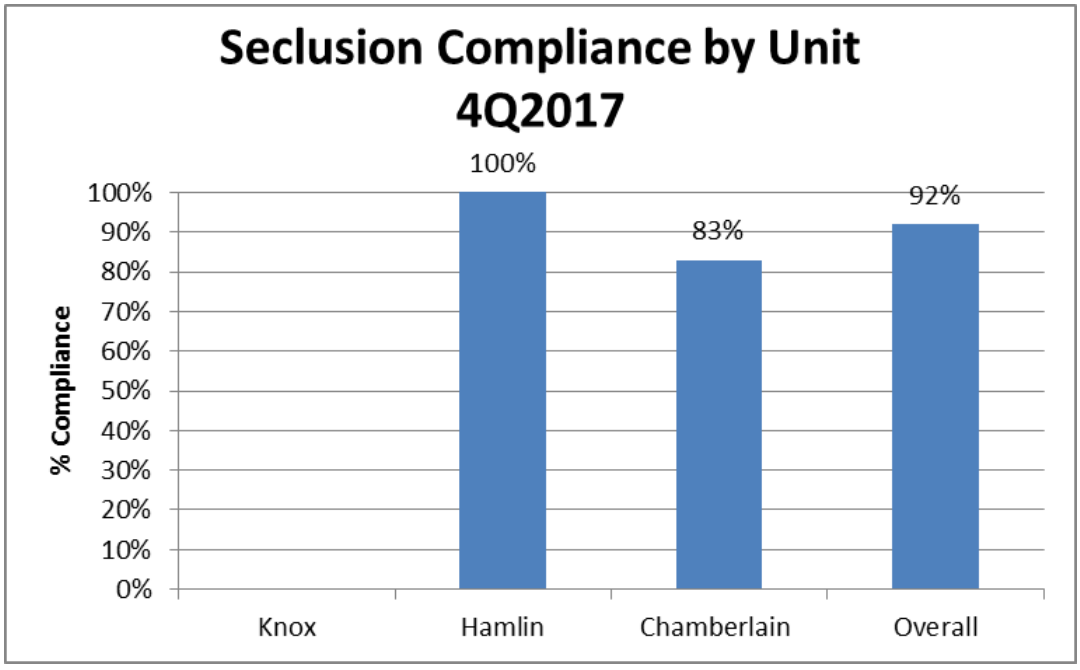
- Knox had no seclusion events during the quarter
- Hamlin had one event during the quarter with a compliance rate of 100%
- Chamberlain had 11 seclusion events with a compliance rate of 83%

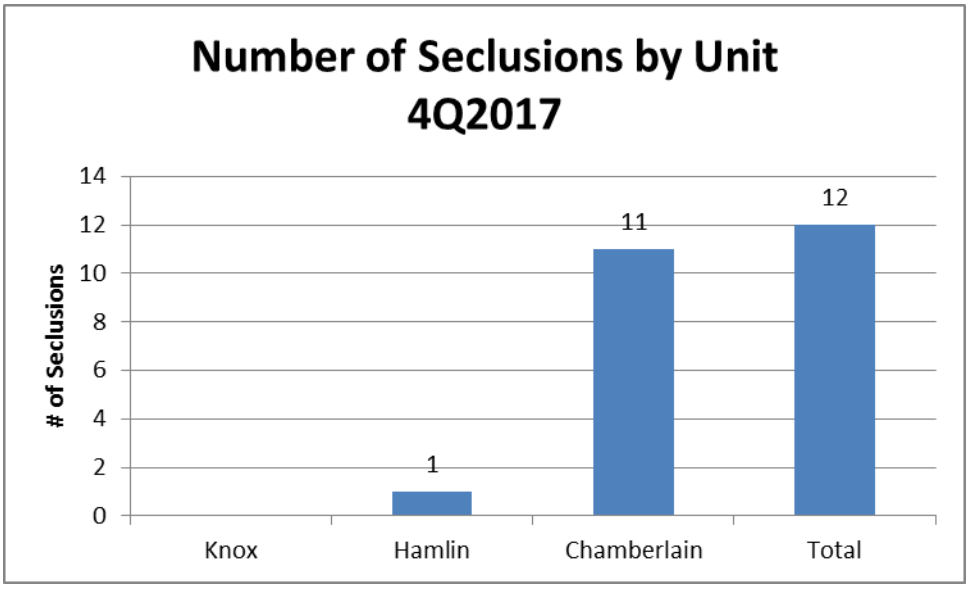
Nursing staff met the 100% goal for four consecutive months for the following four questions. These will no longer be reported on after this 3Q2017 report. These questions will be evaluated by spot-check in six months to evaluate and ensure consistent and reliable documentation compliance. (#13) "On Form #407 Seclusion & Restraint Monitoring and Assessment 15 minute checks are completed at appropriate intervals, with patient's behavior documented in behavioral terms as it pertains to release criteria, times, dated, and initialed by staff?" (#11) "On Form # 407RN 2 Hour Seclusion and Restraint Breaks 2 hour breaks are completed at appropriate intervals and signed by RN?" (#15) "Were debriefings DB1 & DB2 completed at appropriate times?" (#16) "Is patient debriefing in the chart?"

Nursing documentation met the 100% goal for four consecutive months for the following five questions. These will no longer be reported on after the 2Q2017 report. Spot checks of all below measures were 100% successful in the months of May and June. We will again evaluate in six months to ensure consistent and reliable documentation compliance. Questions (#1) "Each order obtained within 15 minutes of the intervention?" (#4) "Is form #408 Nursing Seclusion/Restraint Progress Note complete?" (#5) "On Form #408 Nursing Seclusion/Restraint Progress Note, Form #470 Nursing Assessment Protocol for Seclusion and Restraint, and Physician Orders do times match for interventions initiated and time of events?" (#9) Are details of event similar on all forms without discrepancies #408, #409, and Order sheets?" and (#10) "Is Form # 470 Nursing Assessment Protocol for Seclusion and Restraint completed?"

STRATEGIC PERFORMANCE EXCELLENCE







Action Plan: Nursing staff remains below goal and will continue to audit the documentation of patient seclusions on a monthly basis and re-evaluate quarterly. Nursing documentation will be extracted and separated from Medical Staff documentation. Nursing will compare data gathered from Meditech reporting to ensure all coercive events are captured. There is a possibility that prior to beginning this cross-check in December that events were not captured for data collection.

III. **Measure Name**: **Form 222B will be completed per procedure.**

Measure Description: Special Observations of DDPC patients are recorded on form 222B as part of the permanent medical record. "Special Observations (SO) is a method of preventing acutely disturbed psychiatric inpatients from harming themselves or others. It involves assigning an identified person to the care of the 'at-risk' patient for a certain period of time, above the minimum general level of observation required for all inpatients." SO may be intermittent or constant and may last between a few hours to several weeks; the most frequent reason for SO is prevention of self-harm, but is also used for other patient safety issues [Stewart, D., & Bowers, L. (2012). In accordance with Dorothea Dix Psychiatric Center procedure, all 222B forms will include the following documentation components:

- Patient label
- Observation level (frequency)
- Reason for observation
- Date of form
- 24 hour Charge Nurse coverage
- No incomplete initial or location boxes

May 9, 2017, removed requisite area for charge nurse signature, date, and time as it is understood and communicated that the assigned charge nurse for the shift carries responsibility for the assured completion of the form by appropriate staff.

Type of Measure: Performance Improvement

STRATEGIC PERFORMANCE EXCELLENCE

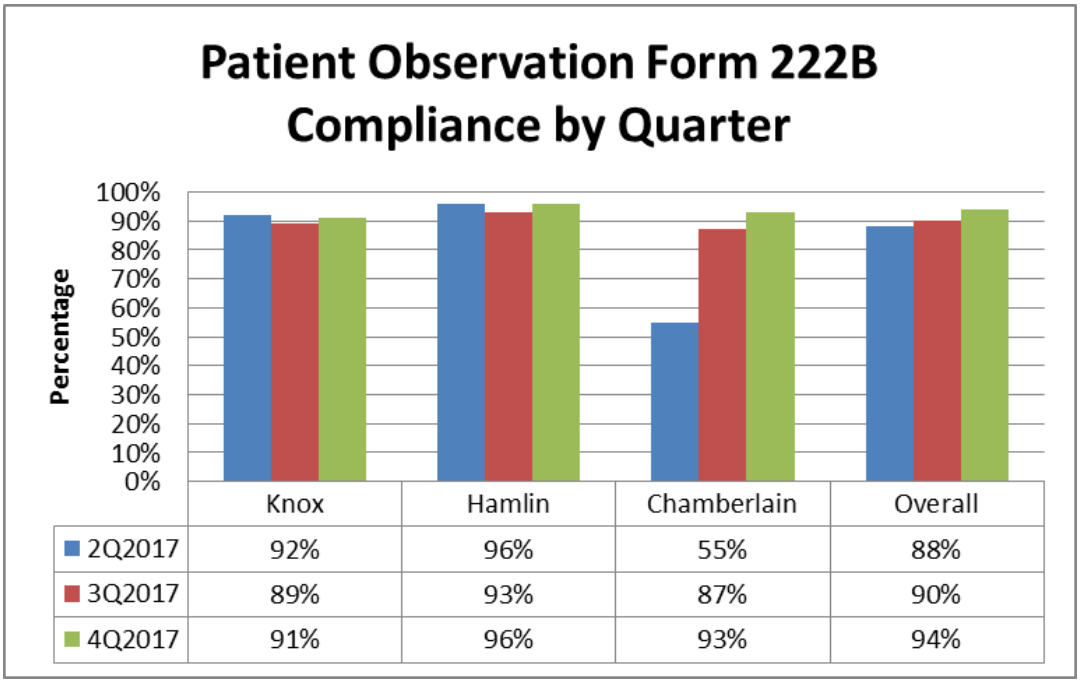
Methodology: Nursing Performance Improvement will collect, review, formulate, and report data from inpatient units for compliance with all elements of form 222B completion. Every 222B patient observation form will be reviewed monthly for compliance using audit tool with boxes for numbers of total expected and total correct 222B forms. The Pass Status Sheet is compared with each unit's supplied 222B forms to ensure full collection. The denominator will be all expected 222B forms; the numerator will be the number of all 222B forms completed correctly within the month. Baseline data established in October 2016 (see chart). November was the first official reporting of this measure; the first quarterly report comprised combined results from November and December, 2016.

The goal is to have a combined compliance score of **90%** for four consecutive months. The results of the audits will be reported to the IPEC committee quarterly and the Advisory board.

	Baseline Oct 2016				2Q2017				3Q2017				4Q2017			
Data Elements	**K1**	**K2**	**K3**	**Total**	**K1**	**K2**	**K3**	**Total**	**K1**	**K2**	**K3**	**Total**	**K1**	**K2**	**K3**	**Total**
Total 222B	54	170	55	**279**	159	173	64	**396**	217	324	228	**769**	159	230	226	**615**
Total Correct 222B Forms	42	161	42	**245**	147	166	35	**348**	193	302	199	**694**	145	222	210	**577**
Overall Compliance	**78%**	**95%**	**76%**	**88%**	**92%**	**96%**	**55%**	**88%**	**89%**	**93%**	**87%**	**90%**	**91%**	**96%**	**93%**	**94%**

Data Analysis: 4Q2017 shows an overall compliance of 94%, 4% above 3Q2017 rate of 90%, up 6% from 2Q2017 and baseline of 88%. By month overall compliance was: April 89%, May 96%, and June 96%.

STRATEGIC PERFORMANCE EXCELLENCE



	Knox	Hamlin	Chamberlain	Overall
2Q2017	92%	96%	55%	88%
3Q2017	89%	93%	87%	90%
4Q2017	91%	96%	93%	94%

Action Plan: Nursing documentation exceeded goal this quarter. Nursing Administration will continue to address deficiencies in documentation with Clinical Nurse Managers and provide information related to each deficiency for unit follow up.

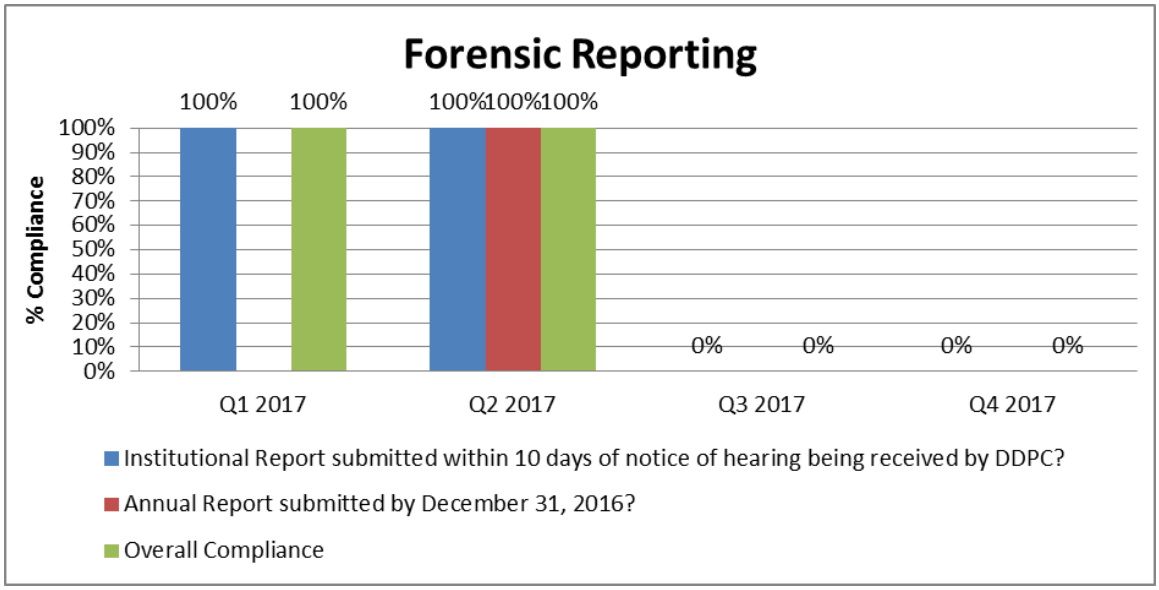
Reference: [Stewart, D., & Bowers, L. (2012). Under the gaze of staff: Special observation as surveillance. Perspectives in Psychiatric Care, 48(1), 2-9. doi:10.1111/j.1744-6163.2010. 00299.x].

STRATEGIC PERFORMANCE EXCELLENCE

Outpatient & Forensic Services — Robyn Fransen, LSW-C

I. **Measure Name**: **Timeliness of Institutional Reports and Annual Reports**
Measure Description: All annual reports are due yearly by December 31, as required by Maine Statute Title 15. Institutional reports are due within 10 days after receiving notice of a filed petition. A tardy filing of an institutional report would delay a forensic patient's evaluation and ability for increased privileges, modified release, and ultimately release and discharge from the custody of the Commissioner.
Type of Measure: Performance Improvement

Results							
Target	**Data Elements**	**Baseline FY2016**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
100%	Total # of Reports Due?	8	4	11	1	3	**19**
	# of Institutional Reports Due?	3	4	2	1	3	**10**
	Institutional Report submitted within 10 days of notice of hearing being received by DDPC?	33%	100%	100%	0%	0%	**50%**
	# of Annual Reports Due	5	0	9	0	0	**9**
	Annual Report submitted by December 31, 2015?	80%	N/A	100%	N/A	N/A	**100%**
	Overall Compliance of reports submitted by due date.	**63%**	**100%**	**100%**	**0%**	**0%**	**50%**

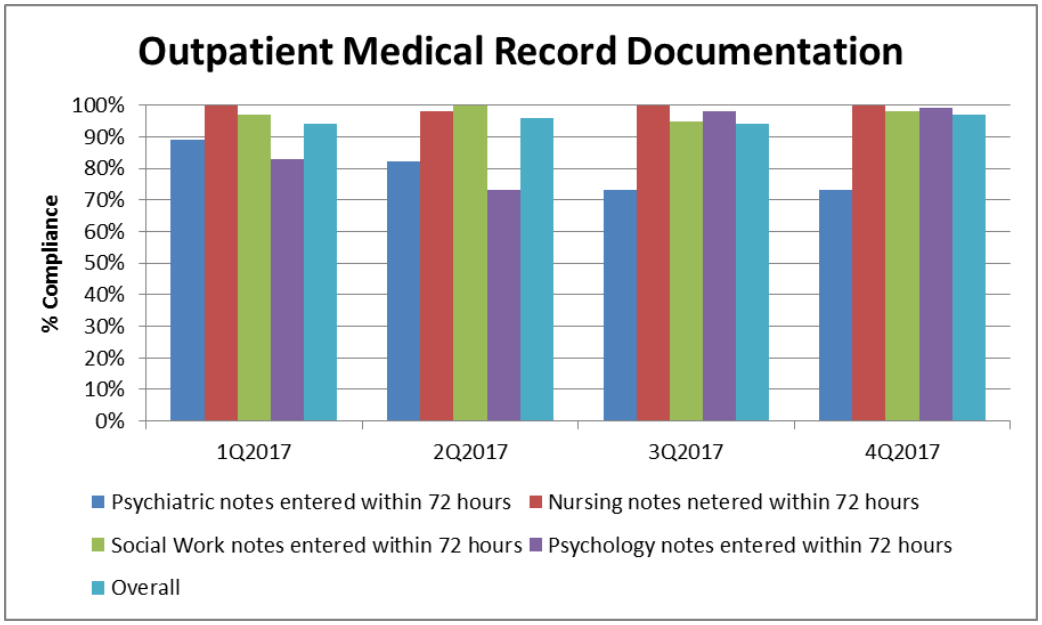


Data Analysis: The data element "Institutional Report Submitted within 10 days of notice of hearing being received by DDPC" was at 0% for 4Q2017, remaining the same as reported for 3Q2017. Attending psychiatrist was not here during the time all three Notice of Hearings were received and the Medical Director needed additional time to complete the Institutional Reports as she was not as familiar with the patients. The data element "Annual Report Submitted by December 31, 2016" is not applicable, as there were no reports due in the 4Q2017.

Action Plan: Continue to track and monitor the completion and submission of the Institutional and Annual reports using a Forensic Timeline Report which will assist in keeping staff notified of upcoming dates. Additional education has been provided to administrative staff about sending hearing notices immediately as it has been determined that the notice of hearing was not sent in a timely manner. Will continue to monitor that hearing notices are being distributed to all members of the forensic team and are date stamped upon receipt and immediately sent to staff so that Institutional Reports can be completed on time.

II. **Measure Name: Timeliness of Medical Record Documentation for Outpatient Services**
Measure Description: All progress notes are promptly filed and readily available in the patient's medical record. This information is necessary to monitor the patient's condition and this and other necessary information must be in the patient's medical record. In order for necessary information to be used it must be promptly filed and available in the medical record so that health care staff involved in the patient's care can access/retrieve this information in order to monitor the patient's condition and provide appropriate treatment and patient services.

Results							
Target	**Data elements**	**Baseline FY2016**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
90%	# of Notes	778	173	312	333	455	**1279**
	Psychiatric notes entered within 72 hours?	83%	89%	82%	73%	73%	**79%**
	Nursing notes entered within 72 hours?	98%	100%	98%	100%	100%	**100%**
	Social Work notes entered within 72 hours?	88%	97%	100%	95%	98%	**98%**
	Psychology notes entered within 72 hours?	78%	83%	73%	98%	99%	**88%**
	Overall Compliance	**89%**	**94%**	**96%**	**94%**	**97%**	**95%**



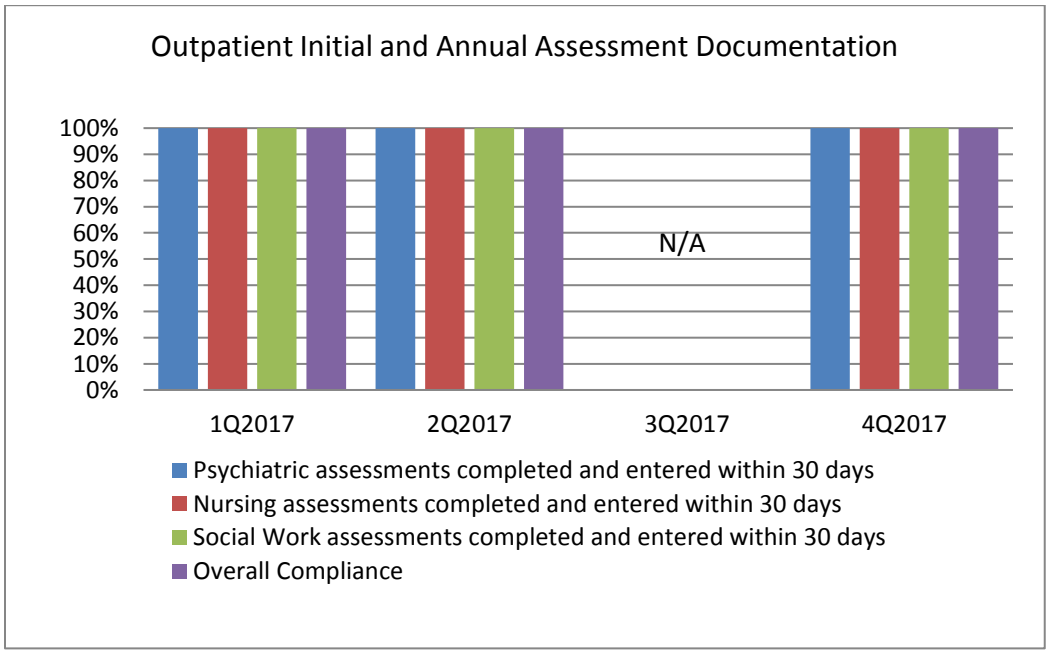
Data Analysis: Data elements "Psychiatric Notes Entered within 72 hours" remained the same at 73% from 3Q2017 to 4Q2017. "Social Work Notes Entered within 72 hours" and "Psychology Notes Entered within 72 hours" increased slightly from 95% to 98% and 98% to 99% respectively. "Nursing Notes entered within 72 hours" remained at 100%. Overall compliance increased from 94% to 97% and remains above the 90% compliance rate. We will continue to focus on psychiatric providers increasing their compliance.

Action Plan: Continue to audit notes on a monthly basis, remind staff of the policy for completing notes, and hold monthly meetings during which documentation will be an ongoing discussion. We will have outpatient nurse check notes after clinic days for compliance. Concerns are forwarded to the appropriate supervisor so that they can be addressed individually as part of ongoing competency evaluations.

III. Measure Name: Timeliness of Initial and Annual Assessment Documentation for Outpatient Services

Measure Description: All initial and annual assessments (psychiatric, nursing, social work) are completed and filed in the patient's medical record and in the electronic medical record within 30 days of the patient's admission and annual date. This information is necessary to monitor the patient's condition. It must be in the patient's medical record. Health care staff involved in the patient's care must be able to access/retrieve this information in order to monitor the patient's condition and provide appropriate treatment and patient services; therefore, necessary information must be entered and available in the medical record promptly.

Results							
Target	**Data elements**	**Baseline FY2016**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
100%	# of Assessments	8	5	3	0	**2**	**10**
	Psychiatric assessment complete and entered within 30 days?	50%	100%	100%	N/A	**100%**	**100%**
	Nursing assessment complete and entered within 30 days?	88%	100%	100%	N/A	**100%**	**100%**
	Social Work assessment complete and entered within 30 days?	88%	100%	100%	N/A	**100%**	**100%**
	Overall Compliance	**75%**	**100%**	**100%**	**N/A**	**100%**	**100%**



STRATEGIC PERFORMANCE EXCELLENCE

Data Analysis: There were two assessments, one initial and one annual, due during 4Q2017. All assessments were 100% compliance. Overall compliance remains at 100%.

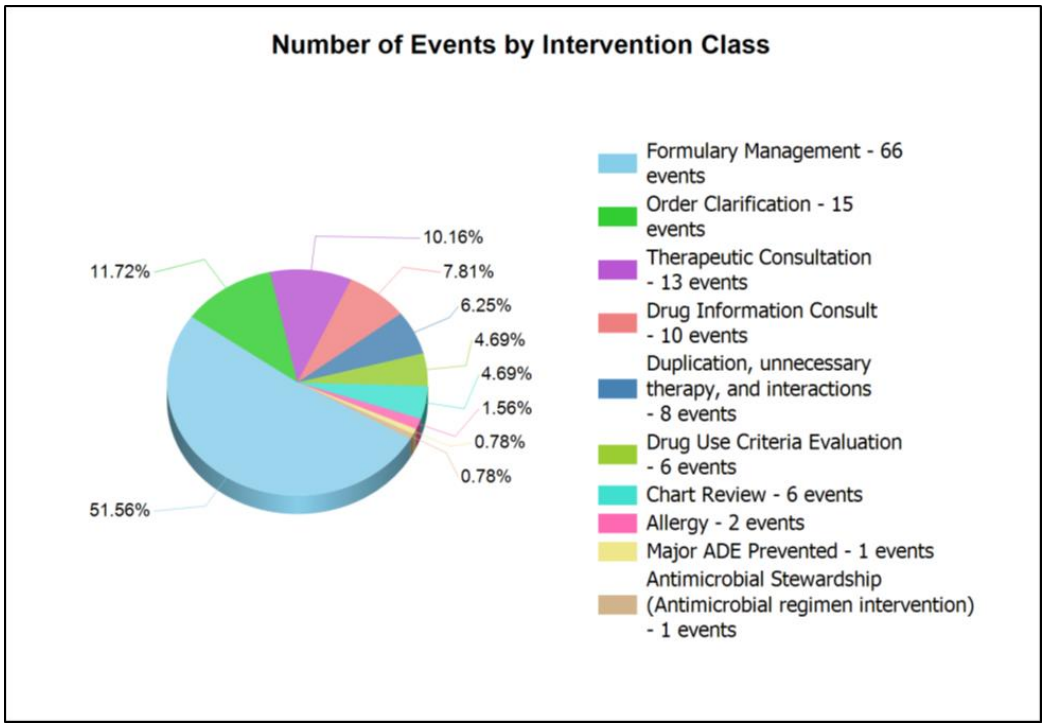
Action Plan: Will continue to audit all assessments on a monthly basis, flagging any upcoming or currently due assessments, and setting weekly reminders on outlook to begin one month before annual date to remind staff of the upcoming due date. Because this measure has remained at 100% compliance through 4Q2017, this performance improvement measure will be moved to a quality assurance measure for FY2018.

STRATEGIC PERFORMANCE EXCELLENCE

Pharmacy Services — Michael Migliore, RPh

I. Measure Name: Medication Management Monitoring
Measure Description: Documentation of Clinical Interventions
Type of Measure: Performance Improvement

	Unit	Baseline 4Q2016	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Actual	Rx	397	867	1246	1338	128	**3579**



Data Analysis: The Pharmacy Department monitors patients' renal function, electrolyte levels, and metabolic parameters to identify areas for medication use optimization, and polyantipsychotic therapy.

Action Plan: DDPC's continuing effort to strive for excellence in patient care involves enhancing current monitoring and reporting.

Comments: The pharmacy team in collaboration with other departments looks forward to the expansion and enhancement of the clinical programs.

STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Medication Management Monitoring
Measure Description: The Psychiatric Emergency Order
Type of Measure: Performance Improvement

	Process Element	No	Yes	1Q 2017	2Q 2017	3Q 2017	4Q 2017	YTD	Reason for non-compliance
Target	Pharmacy received PE orders	0	3	100%	100%	100%	100%	**100%**	
Actual				100%	100%	100%	100%	**100%**	
Target	Did RPh need to resolve PE orders	3	0	0%	0%	0%	0%	**0%**	
Actual				50%	10%	13%	100%	**82%**	
Target	Were PE meds Clearly identified when clarified	0	3	100%	100%	100%	100%	**100%**	
Actual				100%	100%	88%	100%	**97%**	
Target	Was any PE written for up to 72 hours, stopped by writing "Discontinue Emergency Meds"?	3	0	100%	100%	100%	100%	**100%**	
Actual				100%	100%	88%	100%	**97%**	
Target	Was a one-time PE intervention specified as an Emergency Med?	3	0	100%	100%	100%	100%	**100%**	
Actual				100%	100%	100%	100%	**100%**	
Target	Did any Emergency Med not end in 72 hours?	3	0	0	0	0	0	**0**	Some were continued, but had appropriate orders.
Actual				0	0	0	0	**0**	
Target	Was PE co-signed by psychiatrist if ordered by a PA?	N/A	N/A	100%	100%	100%	100%	**100%**	
Actual				N/A	N/A	N/A	N/A	**N/A**	

Data Analysis: There were three orders pertaining to psychiatric emergencies during the 4Q2017.

Action Plan: Continued monitoring and data collection during psychiatric emergencies has resulted in favorable results for the 4Q2017.

Comments: This continues to be an area of focus for DDPC.

STRATEGIC PERFORMANCE EXCELLENCE

III. **Measure Name**: **Medication Management Monitoring**
Measure Description: Shift the Variance occurred on
Measure Type: Performance Improvement

	Units	Baseline 4Q2016	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	All	0	0	0	0	0	**0**
Actual		11	30	12	8	1	**51**
7am-3pm		5	17	7	7	1	**32**
3-11pm		5	10	5	0	0	**15**
11pm-7am		2	3	0	1	0	**4**

Data Analysis: Although most variances occur during the day shift when most medications are passed, the careful monitoring of all shifts and personnel is essential to eliminate trends and patterns that affect patient care.

Action Plan and Comments: The Pharmacy Department will continue to monitor and create medication variances when necessary. Promptly recording and reporting of medication variances is paramount.

STRATEGIC PERFORMANCE EXCELLENCE

IV. **Measure Name**: **Medication Management Monitoring**
Measure Description: Cause of Variance
Measure Type: Performance Improvement

	Baseline 4Q2016	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	0	0	0	0	0	**0**
Actual	11	39	12	8	1	**60**
Two forms of patient ID not used		1	3			**4**
Inaccurate check of MAR						
Not Yellowed on MAR		1				**1**
MD order issues		1				**1**
MAR print out wrong			1			**1**
New order overlooked		2	2			**4**
New order		1	2	1		**4**
High Alert Med		2				**2**
Pyxis loading error		1				**1**
Med Overlooked	8	5	4	2		**11**
Distractions	2	2		1		**3**
Dispensing error						
Procedure not followed	2	18	12	5	1	**36**
Unclear order		1				**1**
Transcription		4	1			**5**

*Please note that the number of causal factors is discrete from the number of variances; each variance may have multiple causes.

Data Analysis: Although the number of fourth quarter variances has decreased, not following procedure was again the most common contributing factor.

Action Plan: Pharmacy will continue to monitor the daily Pyxis activities to ensure proper handling of medications. An interdisciplinary team reviews the variances on a monthly and as-needed basis to quickly address and remedy any concerns.

Comments: The variances and related procedures for reporting and documenting them are continuously monitored, reviewed and discussed. We will continue our efforts to minimize variances and to educate staff on how processes may be improved for optimal patient care.

STRATEGIC PERFORMANCE EXCELLENCE

V. **Measure Name**: **Medication Management Monitoring**
Measure Description: Type of Variance
Type of Measure: Performance Improvement

	Units	Baseline 4Q2016	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	All	0	0	0	0	0	**0**
Wrong Dose		1	3	1			**4**
Extra Dose		1	2				**2**
Wrong Time			3	2			**5**
Wrong Drug			2				**2**
Wrong Form							
Frequency							
Omission		7	10	5	3		**18**
Wrong Patient			1	3			**4**
Schedule				1			**1**
Expired Drug		1					
Procedure Not Followed		1	8		5	1	**14**
Drug Not Loaded			1				**1**
Dispensing							
Total		**11**	**30**	**12**	**8**	1	**51**

Methodology: Prompt review, investigation, and analysis of medication variances include Medical, Risk Management, Pharmacy, Nursing, Quality Assurance and other disciplines when necessary.

Data Analysis, Action Plan and Comments: In an effort to decrease the number of variances DDPC provides education, re-education and training to its staff. The fourth quarter reports a favorable decrease in the number of medication variances.

VI. **Measure Name**: **Medication Management – Controlled Substance Loss Data**
Measure Description: Monthly Pyxis Controlled Drug Discrepancies
Type of Measure: Quality Assurance

	Unit	Baseline 4Q2016	1Q2017	2Q2017	3Q2017	4Q2017	YTD Average
Target	Rx	8.8/ month	0	0	0	0	**0**
# of discrepancies			9.3/ month	6/ month	6.6/ month	1.6/ month	**5.9/ month**
Number of CS lost		0	0	0	0	0	**0**

Data Analysis: There were, on average, 1.6 controlled substance discrepancies per month for the 4Q2017. This metric does not indicate the number of controlled substances lost; instead it illustrates the number of discrepancies that occur, which typically result from miscounts.

Action Plan and Comments: Pharmacy will continue to increase visibility and availability to the units to provide education regarding how Controlled Substance discrepancies occur and how they can be avoided. Pharmacy continues to strive for a 0% loss of controlled substances.

VII. Measure Name: **Safety in Culture and Actions: Fiscal Accountability**
Measure Description: Tracking of Dispensed Discharged Prescriptions
Type of Measure: Quality Assurance

	Unit	Baseline FY2016	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	All	$1145.77 for 101 meds	0	0	0	0	**0**
Actual			$157.16/ 5 Rxs	$26.83/ 17 Rxs	$175.29/ 9 Rxs	$24.59/ 4 Rxs	**$383.87/ 35 Rxs**

Data Analysis: During the 4Q2017, a total of four discharge prescriptions were dispensed totaling $24.59, averaging out to $6.15 per prescription. The fiscal YTD 2017 is approximately 1/3 of the baseline 2015 figure.

Action Plan and Comments: The pharmacy department will continue to monitor and reduce discharge medication costs. Moving forward, the goal is to teach this process of cost containment for discharge medications to the Pharmacy personnel at Riverview Psychiatric Center.

VIII. Measure Name: **Safety in Culture and Actions – Veriform Medication Room Audits**
Measure Description: Monthly Comprehensive Audits of 45 Criteria
Type of Measure: Quality Assurance

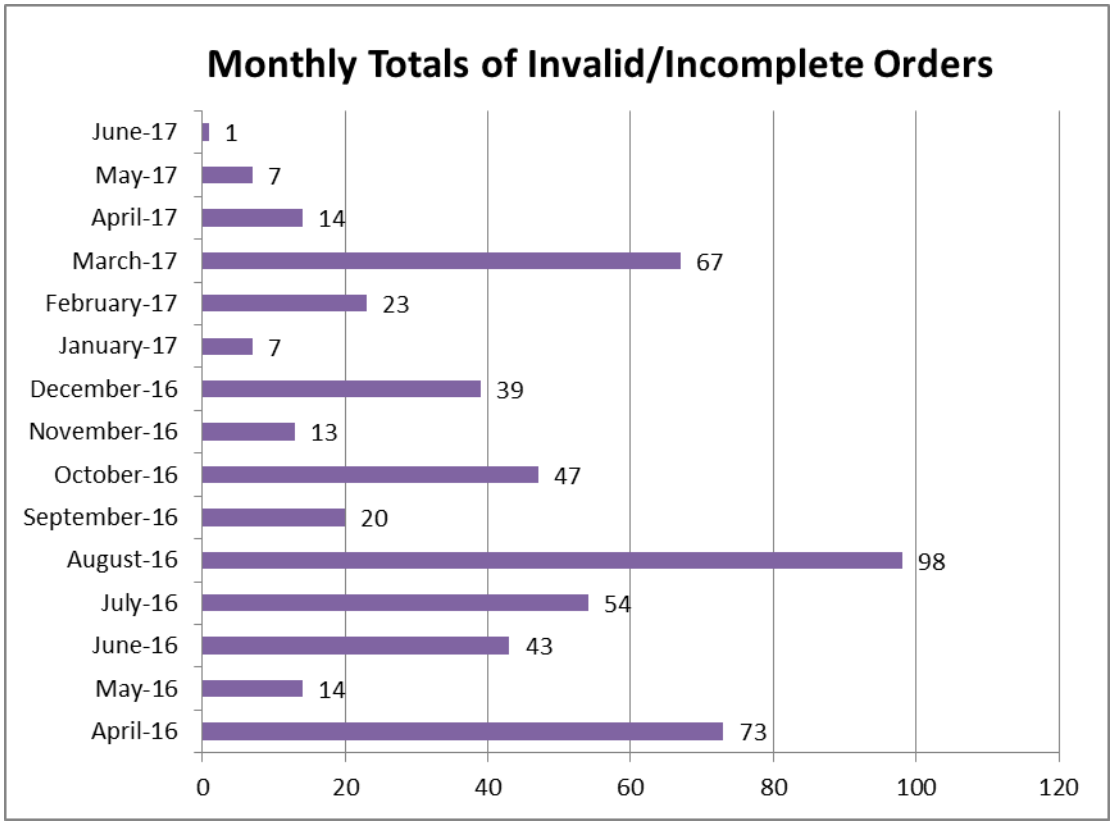
	Unit	Baseline FY 2016	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	All	85%	100%	100%	100%	100%	**100%**
Actual			100%	100%	100%	100%	**100%**

Methodology: On a monthly basis the Pharmacy Department performs comprehensive inspections of medication rooms, central supply areas, and the medical clinic. Over 44 criteria are monitored in the audits utilizing Veriform software.

Data Analysis: Pharmacy continues to strive for audits that are 100% complete.

Action Plan and Comments: The Pharmacy Department will continue to send reminders early in the process to ensure that completion, compliance, verification and reporting is performed in a timely fashion. Interdisciplinary communication and discussion has resulted in favorable year to date results.

IX. Measure Name: Invalid Orders
Measure Description: Incomplete/Invalid Orders
Type of Measure: Performance Improvement



Background: DDPC has a zero tolerance policy for incomplete orders and strives to have every order contain the correct required information to prevent it from being considered invalid. Staff pharmacists promptly address invalid orders by contacting the prescriber and/or the unit to rectify the noted deficiency.

Data Analysis: 4Q2017 results of invalid orders are lower than previous quarters.

Action Plan: Tracking incomplete orders will continue until the implementation of Computerized Provider Order Entry scheduled for June 2017. The system will contain hard stops preventing providers to proceed to initiate an order that is not complete.

STRATEGIC PERFORMANCE EXCELLENCE

X. **Measure Name**: **Polyantipsychotic Therapy (PAPT) Therapy**

Measure Description: The use of two or more antipsychotic medications is discouraged as current evidence suggests little to no added benefit with an increase in adverse effects when more than one antipsychotic is used. The Joint Commission Core (TJC) Measure HBIPS-5 requires that justification be provided when more than one antipsychotic is used. Three appropriate justifications are recognized: 1) Failure of three adequate monotherapy trials, 2) Plan to taper to monotherapy (cross taper) and 3) Augmentation of clozapine therapy. This measure aligns itself with the HBIPS-5 core measure and requires the attending psychiatrist to provide justification for using more than one antipsychotic. In addition to the justification, the clinical/pharmacological appropriateness is also evaluated.

Type of Measure: Quality Assurance

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Polyantipsychotic Therapy	TBD	20%	20%	20%	20%	**20%**
Actual			33.6%	21%	20.9%	20%	**23.9%**

Data Analysis: While justification has been a component of discussion prior to initiating polyantipsychotic therapy (PAPT), it was completed on a case-by-case basis. This data represents the first step in developing that formalized process. Beginning in July, it was decided that data would be collected in a centralized manner and presented to the Pharmacy & Therapeutics Committee to create a baseline data set of PAPT. For 4Q2017, 20% of patients at DDPC were receiving treatment with more than one antipsychotic.

Action Plan: DDPC will continue to develop the formalized PAPT tracking and reporting the findings to the Clinical Director and prescribers at the facility. A formal, centralized process for PAPT will enable the facility to better optimize the patients' therapies, identify trends and areas for improvement, all while striving for excellence in patient care. Formal therapy justifications are also being collected and will become part of the report for the next fiscal year.

STRATEGIC PERFORMANCE EXCELLENCE

XI. Measure Name: **Metabolic Monitoring**

Measure Description: Metabolic syndrome is a well-known side effect of second generation antipsychotics (SGAs) and represents a common comorbidity in the psychiatric population. The majority of patients prescribed antipsychotics are prescribed an entity from the SGA sub-class. The purpose of this is to ensure that DDPC is monitoring the patients it serves appropriately and to the best of its ability, while mitigating the consequences of metabolic syndrome as much as possible.

Type of Measure: Performance Improvement

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Complete/ Up-to-date Metabolic Parameters	73%	50%	65%	70%	75%	**75%**
Actual			69.9%	85.7%	82.4%	91%	**82.25%**

Data Analysis: The pharmacy completes data collection of metabolic monitoring parameters for all hospital patients on at least a monthly basis. Data elements collected on all patients included BMI (Body Mass Index) and BP (blood pressure), in addition to lab results including HDL cholesterol, triglycerides, fasting blood sugar, and hemoglobin A1C. As this program began at DDPC in July of 2016 an initial goal of having at least 50% of patients with complete monitoring parameters was determined. Pharmacy worked closely with the medical providers and continued to surpass the goals set forth for the year, with the fourth quarter coming in at 91% of patients being completely monitored.

Action Plan: We will continue to monitor for Metabolic Syndrome in DDPC's patients, and particularly those using SGA therapy. The patients' right to refuse assessment (weight, blood pressure and lab work) has been identified as the major contributing factor to not fully assessing the metabolic status of all DDPC's patients. The pharmacy and the medical providers are both excitedly looking forward to the successful implementation and maintenance of this very important clinical program, which is expected to meet the goals outlined above to continue striving for excellence in patient care. To aid providers with the task of maintaining up-to-date metabolic reviews of the patients, pharmacy will continue to maintain the monitoring spreadsheet and will regularly report the findings to the providers.

Comments: We are very pleased to find that he majority of DDPC's patients are currently appropriately monitored for metabolic syndrome, allowing for more timely identification of metabolic syndrome to initiate indicated treatment. The collaboration between pharmacy and the medical providers is expected to increase the patients with up-to-date metabolic parameters with the ultimate goal of reducing the development of comorbidities and allowing for the proper management of them in patients with existing metabolic conditions.

XII. Measure Name: Turn-Around Time Audit

Measure Description: Comprehensive Pharmacy Services has several contractual parameters to meet to ensure timely and appropriate service to Dorothea Dix Psychiatric Center: 1) all orders will be delivered within 3 hours of request; 2) all STAT/ASAP orders will be delivered within 1 hour; 3) all requests for clinical pharmacy consultation will be responded to within 2 working days.

Type of Measure: Quality Assurance

Dorothea Dix Psychiatric Center of Bangor ME

4/1/2017 - 4/30/2017 (30 days) (Report was generated based on Eastern Time

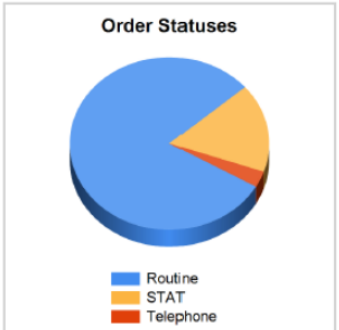
Orders	
Total Orders	66
Average Orders Per Day	2.20

Order Status	# Orders	% of Total
Routine	53	80.3%
STAT	11	16.67%
Telephone	2	3.03%

Line Items	
Order Line Items	119
Adjustment Line Items	0
Total Line Items	119
Average Line Items Per Day	3.97

Interventions	
Total Interventions	19

Turnaround Time	
Average Turnaround Time (In Minutes)	22.35
Average Processing Time (In Minutes)	6.24

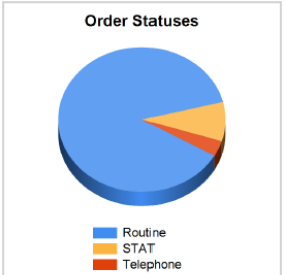


STRATEGIC PERFORMANCE EXCELLENCE

Dorothea Dix Psychiatric Center of Bangor ME

5/1/2017 - 5/31/2017 (31 days) (Report was generated based on Eastern Time

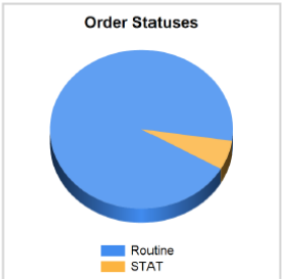
Orders		
Total Orders		57
Average Orders Per Day		1.84
Order Status	**# Orders**	**% of Total**
Routine	50	87.72%
STAT	5	8.77%
Telephone	2	3.51%
Line Items		
Order Line Items		111
Adjustment Line Items		0
Total Line Items		111
Average Line Items Per Day		3.58
Interventions		
Total Interventions		30
Turnaround Time		
Average Turnaround Time (In Minutes)		29.26
Average Processing Time (In Minutes)		8.25



Dorothea Dix Psychiatric Center of Bangor ME

6/1/2017 - 6/30/2017 (30 days) (Report was generated based on Eastern Time

Orders		
Total Orders		50
Average Orders Per Day		1.67
Order Status	**# Orders**	**% of Total**
Routine	47	94%
STAT	3	6%
Line Items		
Order Line Items		106
Adjustment Line Items		0
Total Line Items		106
Average Line Items Per Day		3.53
Interventions		
Total Interventions		18
Turnaround Time		
Average Turnaround Time (In Minutes)		32.90
Average Processing Time (In Minutes)		8.40



Data Analysis: The overnight pharmacy service provider met all contract requirements.

Action Plan: All orders processed after hours are monitored every day by the Staff Pharmacist to ensure they are entered correctly and on a timely basis. Any issues that arrive during the review are addressed that day. The service provider sends reports at the end of the month for review. These processes will be continued.

STRATEGIC PERFORMANCE EXCELLENCE

XIII. Measure Name: Medication Dispensing Process

Measure	Unit	Baseline 4Q2016	Goal	1Q2017	2Q2017	3Q2017	4Q2017
Controlled Substance Loss Data:							
Daily Pyxis-CII Safe Compare Report.	All	0%	Target: Actual:	0% 0%	0% 1%	0% 0%	0% 0%
Monthly CII Safe Vendor Receipt Report.	Rx	0	Target: Actual:	0 0	0 0	0 0	0 0
Monthly Pyxis Unresolved Controlled Drug Discrepancies.	All	0/ month	Target: Actual:	0 0	0 0	0 0	0 0
Medication Management Monitoring:							
Measures of drug reactions, adverse drug events and other management data.	Rx	1.25	Target: Actual:	0 0	0 2	0 2	0 1
Resource Documentation Reports of Clinical Interventions.	Rx	397	Actual:	867	1246	1338	128

STRATEGIC PERFORMANCE EXCELLENCE

Social Services — Tammy Cooper, LCSW

I. Measure Name: 30 Day Readmissions Modified Root Cause Analyses

Measure Description: Once the hospital has identified potentially preventable readmissions, it is expected to conduct an in-depth review of the discharge planning process for a sample of such readmission (at least 10% of potentially preventable readmissions, or 15 cases/quarter, whichever is larger is suggested but not required), in order to determine whether there was an appropriate discharge planning evaluation, discharge plan, and implementation of the discharge plan.

Type of Measure: Quality Assurance

Having identified factors that contribute to preventable readmissions, hospitals are expected to revise their discharge planning and related processes to address these factors.

Methodology: All 30 day readmissions to include admissions within the Progressive Treatment Program (PTP) will be reviewed monthly by using a modified root cause analysis tool. The denominator will be all 30 day readmissions and the numerator will be all patients with a completed modified root cause analysis within 45 days of readmission.

Baseline Data: To be determined

Goal: The goal is to have 100% compliance with the completion of a 45 day modified root cause analysis for all 30 day readmissions.

Month	Pt FD #	Date of Readmission	Date of Completed Modified RCA	% Compliance
April 2017	FD0000119651 FD0000119685	4/18/17 4/26/17	5/2/17 5/2/17	100% 100%
May 2017	N/A	N/A	N/A	N/A
June 2017	N/A	N/A	N/A	N/A

Data Analysis: There were two 30 day readmissions in the 4Q2017. Both were in April, were due to the patient needing medical attention that Dorothea Dix doesn't provide, and both were transferred to a medical hospital and admitted for a period of time.

Action Plan: Continue to monitor

STRATEGIC PERFORMANCE EXCELLENCE

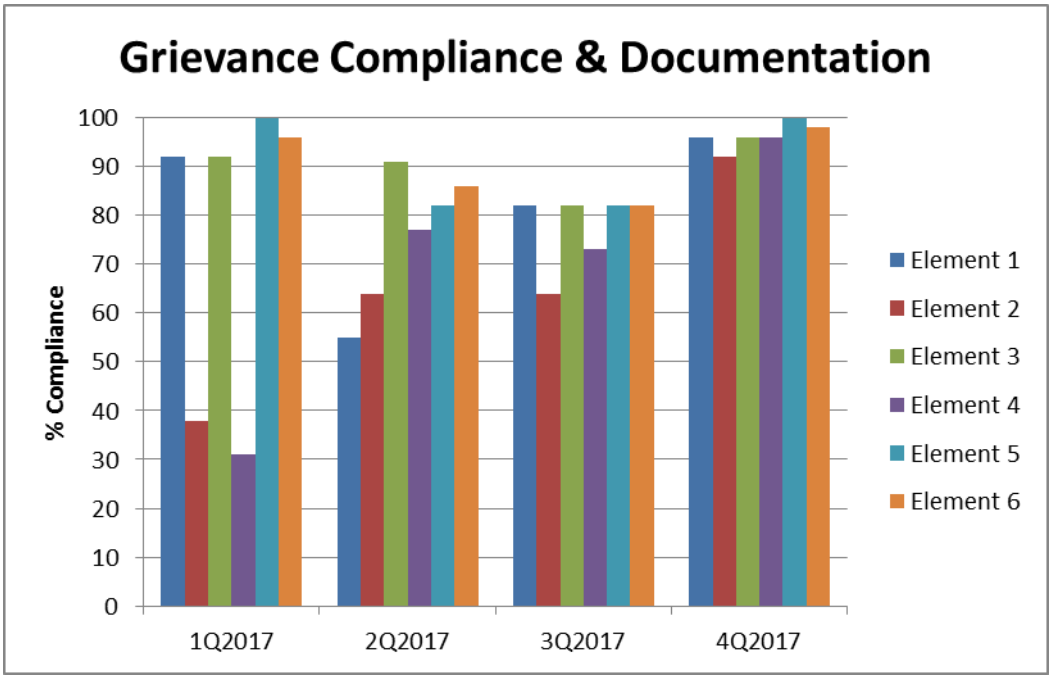
Results							
Target	**Data elements**	**Baseline 4Q2016**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD Average**
	Readmissions within 30 days of discharge	2	3	0	2	2	**2**
	Progressive Treatment Plan (PTP) readmissions within 30 days	1	2	0	0	0	**1**
	45 day root cause analyses due within the quarter	2	2	0	2	2	**2**
100%	**Compliance with completion of a 45 day modified root cause analysis for all 30 day readmissions**	**100%**	**100%**	**N/A**	**100%**	**100%**	**100%**

STRATEGIC PERFORMANCE EXCELLENCE

II. **Measure Name**: **Grievance Compliance and Documentation**.
Measure Description: Addressing grievances in a timely manner allows potential rights violations to be resolved quickly therefore allowing patients and staff to continue to focus on treatment. A Nurse Supervisor must speak with the patient within four hours of notification of the grievance. Social Services must deliver a response to the patient within five days, with five days more if the grievant is notified, and with agreement of the Patient Advocate.
Measure Type: Performance Improvement

Results							
Target	**Data elements**	**Baseline FY 2016**	**1Q 2017**	**2Q 2017**	**3Q 2017**	**4Q 2017**	**YTD**
100%	# of Events	46	13	22	11	25	**71**
	Unit Staff compliant with addressing grievance?	89%	92%	55%	82%	96%	**81%**
	Unit Staff completed form correctly (boxes checked, dated/timed, all signatures completed, Nurse Supervisor notified)?	63%	38%	64%	64%	92%	**65%**
	***Nursing Supervisor compliant with addressing grievance within 4 hours?	86%	92%	91%	82%	96%	**90%**
	Nurse Supervisor completed form correctly (boxes checked, dated/timed, all signatures completed, forwarded to Social Worker)?	61%	31%	77%	73%	96%	**69%**
	***Social Worker compliant with addressing grievance within 5 days or within 5 more days if extension is requested?	100%	100%	82%	82%	100%	**91%**
	***Overall Compliance of Nursing Supervisor and Social Worker addressing grievance**	**93%**	**96%**	**86%**	**82%**	**98%**	**91%**

STRATEGIC PERFORMANCE EXCELLENCE



- Element 1: Unit Staff compliant with addressing grievance
- Element 2: Unit Staff completed form correctly and notified Nurse Supervisor
- Element 3: Nurse Supervisor addressed grievance within four hours
- Element 4: Nurse Supervisor completed form correctly and forwarded to Social Worker
- Element 5: Social Worker addressed grievance within five days or more than five days if extension is requested
- Element 6: Overall Compliance of Nursing Supervisor and Social Worker Addressing Grievance

Data Analysis: All data elements increased from 3Q2017 to 4Q2017. Overall compliance increased from 82% to 98% but is still below the goal of 100%, although has improved significantly.

Action Plan: Previous action steps appear to have helped improve compliance. With changes in nurse supervisor staffing, will present to the Director of Nursing to change to having the CNM address these during the day; and to also discuss if we need the 4 hour response if filed in the evening, or whether those could be responded to by the CNM the next day, with the exception of weekends. Further training by patient advocates and management for unit staff would be beneficial. Continued education on procedure for new staff will be continued as well.

STRATEGIC PERFORMANCE EXCELLENCE

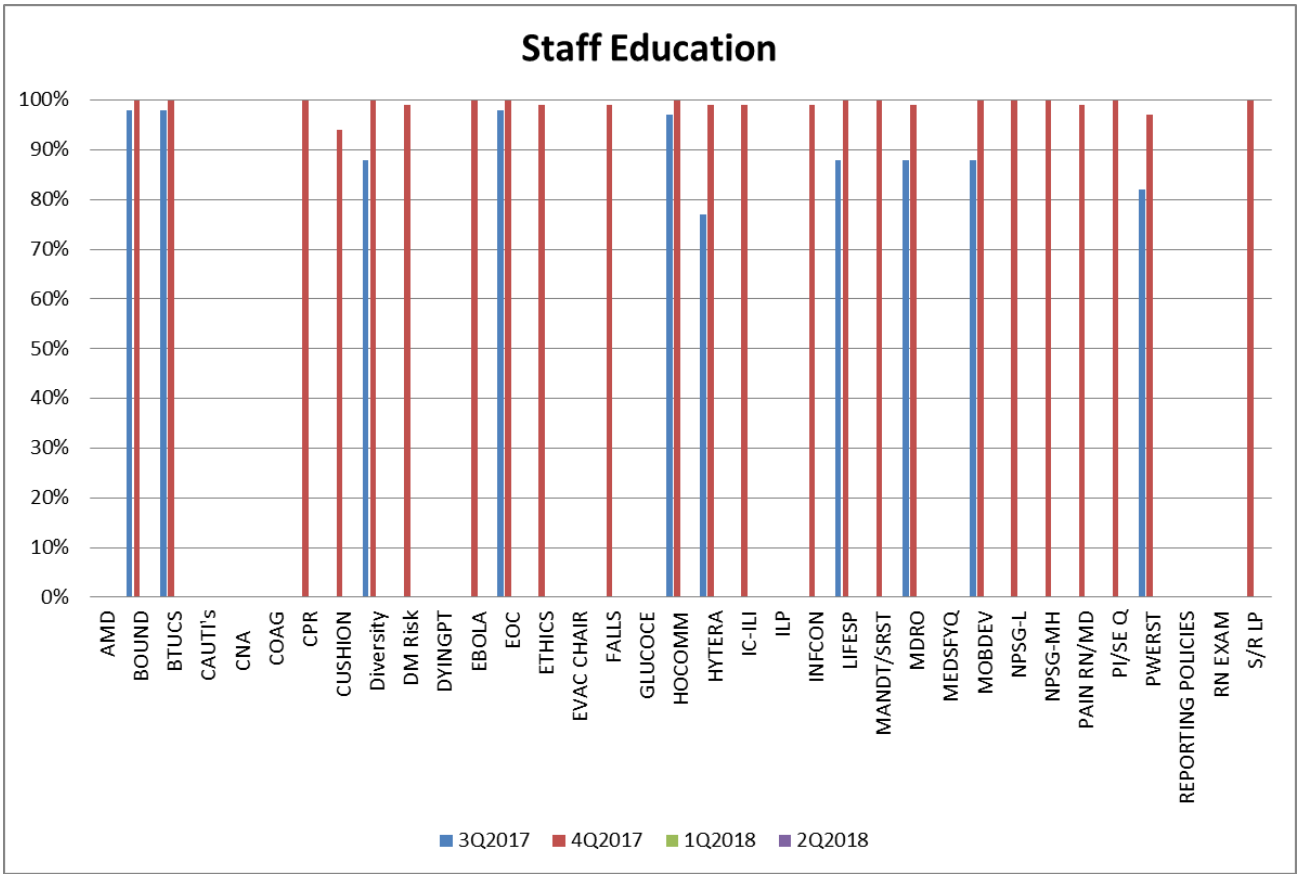
Staff Education and Development — Jenny Bamford-Perkins, MSN, RN

I. Measure Name: Mandatory Staff Education

Measure Description: Both direct and non-direct care employees of Dorothea Dix Psychiatric Center are required to complete monthly mandatory staff education. The Staff Education Department will conduct monthly audits using the education database.

Type of Measure: Performance Improvement

Methodology: The numerator will be the number of staff that completed their monthly education requirements for the quarter and the denominator will be the total number of staff for the quarter. The goal is to have 100% compliance of monthly education requirements by the staff education year end in 2Q of each fiscal year.



Data Analysis: The graph above and the table below reflect staff education requirements through 4Q2017. This is Staff Education's second quarter requirements for calendar year 2017. Percentages for the Staff Education year ending 12/31/17 will be reflected in the 2Q2018 report.

STRATEGIC PERFORMANCE EXCELLENCE

Learning Packets	3Q2017	4Q2017	1Q2018	2Q2018
AMD				
BOUND	98%	100%		
BTUCS	98%	100%		
CAUTI's				
CNA				
COAG				
CPR	100%	100%		
CUSHION		94%		
Diversity	88%	100%		
DM Risk		99%		
DYINGPT				
EBOLA		100%		
EOC	98%	100%		
ETHICS	82%	99%		
EVAC CHAIR				
FALLS	82%	99%		
GLUCOCE				
HOCOMM	97%	100%		
HYTERA	77%	99%		
IC-ILI	77%	99%		
ILP				
INFCON	77%	99%		
LIFESP	88%	100%		
MANDT/SRST	100%	100%		
MDRO	88%	99%		
MEDSFYQ				
MOBDEV	88%	100%		
NPSG-L	88%	100%		
NPSG-MH	83%	100%		
PAIN RN/MD	77%	99%		
PI/SE Q	84%	100%		
PWERST	82%	97%		
REPORTING POLICIES	82%	99%		
RN EXAM				
S/R LP	84%	100%		
TJCREP	84%	99%		

Action Plan: Staff Education will complete monthly audits of requirements as they become due, send monthly emails to staff that have not completed their learning packets, send a notice to supervisors prior to the staff education year end to address their staff that are out of compliance, and will alert the Superintendent of employees out of compliance.

II. Measure Name: First Aid Training

Measure Description: Direct Care Staff will be able to render appropriate First Aid on a distressed or injured patient that is in seclusion, restraint, or during any other emergency event.

Type of Measure: Performance Improvement

Methodology: The numerator will be the number of staff that attended First Aid training for the quarter and the denominator will be the number of staff scheduled to attend the First Aid training for the quarter. The goal is to have 100% of the required staff to have the training by the last quarter of FY 2017.

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**FY2017**
Target	Number of Employees	0%	0%	0%	30%	60%	**100%**
Actual			0%	0%	97%	100%	**100%**

Data Analysis: Data indicates that for fiscal year ending June 30, 2017, 100% of staff have completed the First Aid Training requirements.

Action Plan: Staff Education will complete monthly audits and send emails to staff that have not completed their first aid requirement, send a notice to supervisors prior to the staff education year end to address their staff that are out of compliance, and will alert the Superintendent of employees out of compliance.

STRATEGIC PERFORMANCE EXCELLENCE

Therapeutic Services — Lisa J. Hall, OTR/L

I. **Measure Name**: **Provider Direct Patient Contact**

Measure Description: In order to receive effective treatment that will allow patients to return to a satisfying and meaningful life in their chosen community, staff must provide engagement, assessment and treatment that is targeted to meet their individual needs. The first step for performance improvement is increasing direct contact with patients.

Each provider will reach and maintain a 45% direct care productivity standard for three consecutive months. Direct care stats are monitored weekly for staff who have not consistently met the standard, including new staff added throughout the quarter.

Numerator: number of hours spent in direct contact with patients

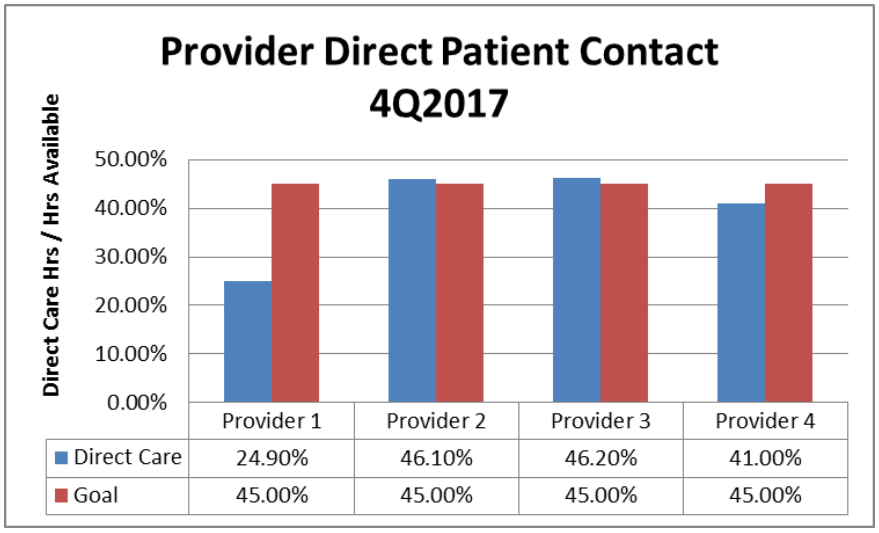
Denominator: number of hours available to spend in direct contact with patients

Type of Measure: Performance Improvement

	Unit	Baseline	1Q2017	2Q2017	3Q2017	4Q2017	YTD
Target	Percent of staff meeting expectation	Dec. 2017 50% (11/22)	N/A	50% (Baseline)	70%	90%	90%
Actual			N/A	50% 11/22	77% 17/22	82% 18/22	70% 46/66

Data Analysis: After two years of expecting 50% direct patient care, a targeted approach to staff intervention was utilized for those not meeting the goal in order to identify barriers. Two additional providers have met the standard since last quarter with three more providers on track to meet and exceed the department goal of 90% in August.

Action Plan: Now that 90% of staff have achieved the goal, quality assurance monitoring will occur one week per quarter for all staff. Dips in direct care will be addressed by individual performance review.

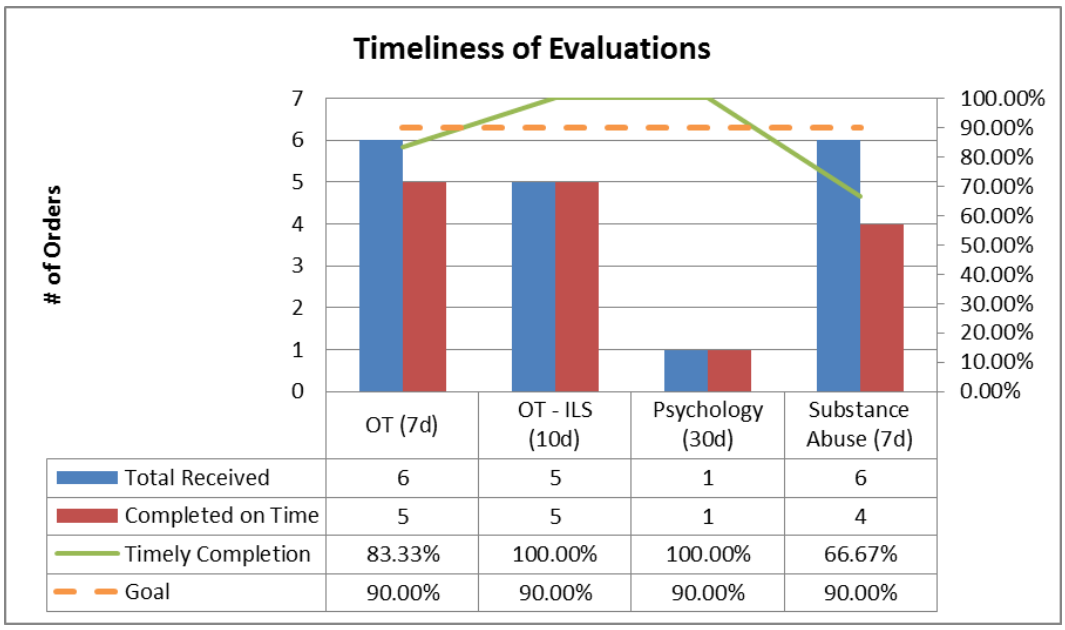


STRATEGIC PERFORMANCE EXCELLENCE

II. Measure Name: Timely Assessment / Improving Health Outcomes

Measure Description: In order to receive effective treatment that will allow patients to return to a satisfying and meaningful life in their chosen community; staff must provide engagement, assessment and treatment that is targeted to meet their individual needs. The formal beginning to a treatment relationship begins with an assessment of strengths and needs to guide the treatment plan. At each treatment plan meeting staff is expected to come prepared to share their area of expertise and propose what treatment offerings they will make available to the patient. To best guide treatment, discipline specific assessments must be complete and available in the patient record.

Type of Measure: Performance Improvement



	OT (7d)	OT - ILS (10d)	Psychology (30d)	Substance Abuse (7d)
Total Received	6	5	1	6
Completed on Time	5	5	1	4
Timely Completion	83.33%	100.00%	100.00%	66.67%
Goal	90.00%	90.00%	90.00%	90.00%

Data Analysis: One OT referral was completed late resulting in 83% timely completion. One hundred percent of the OT-ILS orders were completed on time. The two late substance abuse evaluations were completed a day late in both instances. One psychological evaluation was completed on time. Two were cancelled due to patient's inability to participate in testing or refusal. One order is currently in progress.

Action Plan: As of June 4, 2017, OT orders will be obtained on admission for all patients, and evaluations must be completed prior to the initial RTP meeting. Compliance has been well established, will monitor informally. Two Psychology positions are vacant as of August, 2017. Timeliness of substance abuse evaluations will continue to be monitored for FY2018.

STRATEGIC PERFORMANCE EXCELLENCE

A. Occupational Therapy Evaluations

Goal: Occupational therapy evaluations to include self-care, community participation, health and well-being, life skills development, self-regulation, physical rehabilitation orders will be completed within seven days of referral.

Numerator: Occupational therapy evaluations (less ILS) completed within seven days of the order.

Denominator: Total occupational therapy evaluations (less ILS) received.

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of assessments completed on time	**41%**	N/A	90%	90%	90%	**90%**
Actual			N/A	41% (Baseline)	73%	83%	**66%**

B. Occupational Therapy: Evaluation of Placement Needs (ILS)

Goal: ILS evaluations will be completed within ten days of referral.

Numerator: ILS evaluations completed within ten days of referral.

Denominator: All ILS evaluations received.

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of assessments completed on time.	**58%**	N/A	90%	90%	90%	**90%**
Actual			N/A	58% (Baseline)	80%	100%	**79%**

C. Substance Abuse Assessment

Goal: Substance abuse assessment completed within seven calendar days of the referral.

Numerator: Substance abuse assessments completed within seven days of referral.

Denominator: All substance abuse assessment referrals received

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of assessments completed on time.	50% May 2016	90%	90%	90%	90%	**90%**
Actual			100%	33%	60%	67%	**65%**

D. Psychology – Issue Specific Evaluation

Goal: Psychological evaluations completed within 30 days of referral.

Numerator: Psychological evaluations completed within 30 days of referral.

Denominator: All Psychological evaluations received.

Results							
	Unit	**Baseline**	**1Q2017**	**2Q2017**	**3Q2017**	**4Q2017**	**YTD**
Target	Percent of assessments completed on time	0% May 2016	90%	90%	90%	90%	**90%**
Actual			0%	17%	50%	100%	**42%**

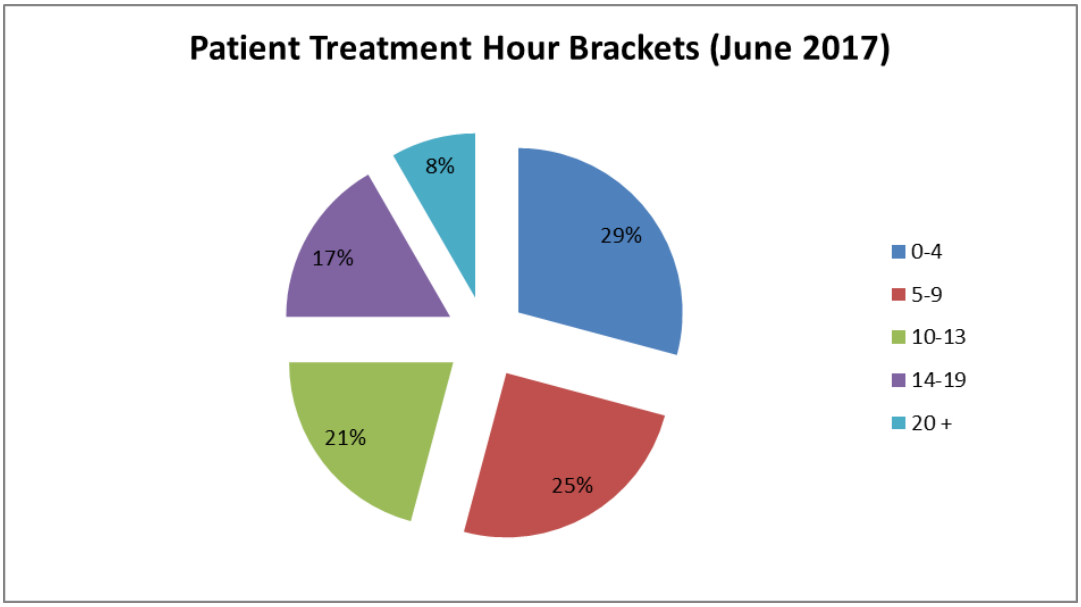
STRATEGIC PERFORMANCE EXCELLENCE

III. Measure Name: Provision of Therapeutic Services

Measure Description: In order to receive active treatment at a frequency and intensity to provide efficient treatment and discharge planning, the goal is for 75% of the patient population to engage in 14 hours of active treatment provided by the therapeutic services department each week. Of the 24 charts audited each month (72 per quarter), the goal is for 75% of the charts audited to reflect at least 14 hours of therapeutic services per week. The hours of treatment, per patient, will be rounded to the nearest whole number.

Type of Measure: Performance Improvement

	Results						
	Unit	**Baseline**	**1Q2018**	**2Q2018**	**3Q2018**	**4Q2018**	**YTD**
Target	14 hours of documented treatment per chart	June 2017 25% 6/24	40%	55%	70%	75%	
Actual							



Data Analysis: Focus discussion on patients with less than four hours of treatment per week. Notify unit OT/RT when audit findings indicate patient is receiving less than four hours of documented treatment.

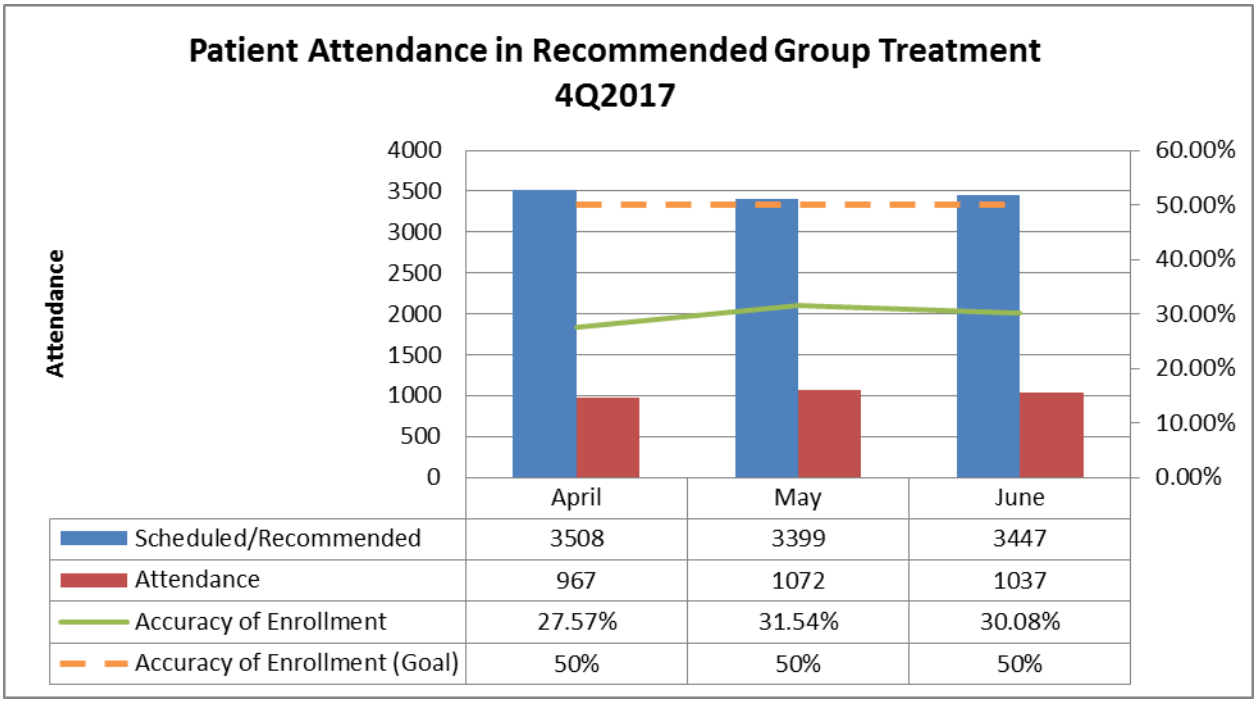
Action Plan: Re-assign OT, RT, and Habilitation Aide's to the units.

STRATEGIC PERFORMANCE EXCELLENCE

IV. Measure Name: Patient Attendance in Recommended Group Treatment

Measure Description: Patients and treatment teams will select groups that are targeted toward building social skills and/or developing coping strategies that will better prepare patients to return to and succeed in the community. Ensuring patients attend groups that are in their treatment plan is part of active treatment. As such, tracking patient's attendance in groups that have been recommended began in March 2017.

Type of Measure: Performance Improvement



	April	May	June
Scheduled/Recommended	3508	3399	3447
Attendance	967	1072	1037
Accuracy of Enrollment	27.57%	31.54%	30.08%
Accuracy of Enrollment (Goal)	50%	50%	50%

Data Analysis: 4Q2017 saw a 5% Improvement over baseline data with group database creation and distribution, and overhead announcement or daily patient signup as proposed at the clinical executive committee meeting on March 3, 2017.

Action Plan: Recreation staff (habilitation aides) will be assigned to a unit and responsible for inviting identified patients to recommended groups as stated in their treatment plans.